

Resident Handbook

**Mercy Redding Family Practice
Residency Program**

2017-2018

Resident Handbook

Mercy Redding Family Practice Residency Program

2017-2018

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Resident Handbook

Mercy Redding Family Practice Residency Program

I. Welcome

Our Educational Philosophy:

We recognize our family practice residents as adult learners who will achieve clinical competence through an evidence based competency directed experience. We are committed to providing appropriate clinical experiences and effective supervision and teaching to achieve the highest level of competency.

RESIDENCY MISSION

Is threefold: to graduate family physicians who are highly qualified to practice in rural and suburban areas, to provide care to the medically underserved in our community (especially in rural settings), and to further the science and practice of family medicine through the application of Information Technology and Management.

At its inception in 1975, the Family Practice Residency Program was based at the Shasta General Hospital in Redding, California. The program began with the mission to produce well-trained family physicians to enter practice in the surrounding region. Our graduates have met many of those needs, especially as the population has grown, but there remain substantial, under-served populations in the north state in need of basic primary care services. A fundamental goal of this residency is to meet these needs, while advancing the practice of health promotion and disease prevention in the community.

In February of 1988, Shasta General Hospital closed. Through the efforts of many, but perhaps most notably the resident staff, sponsorship of the residency program was transferred to Mercy Medical Center, Redding. With our new hospital partner, the underlying residency mission to address the unmet health needs of the north state, through training qualified family physicians was reaffirmed. The Sisters of Mercy, and parent organization Dignity Health, sponsor this residency program as a tangible effort to meet the needs of the poor and under-served in our community. We welcome you to share this mission.

In your role as a family physician in training, you will be called upon, in widely varied and often challenging circumstances, to provide competent and compassionate care to others. With the support of your fellow residents, the residency faculty, the hospital and community, you will further your confidence and skills as a physician. We challenge you to take a broad perspective of your developing role as a family physician. You have entered training as a generalist, but beyond that, the community in which you practice will need you as a community physician. Use your time with us to enhance your understanding of, and effectiveness in, working with the

community you serve. In doing so, you will truly reach your potential to positively impact the lives of your patients.

While becoming a family physician, we do not expect you to sacrifice your life outside of residency. Family Practice training can be a demanding task, yet truly effective family doctors have learned to balance their personal needs for fulfillment with the demands of their job. While short-term compromises must be made, our goal is to support a healthy personal, family and emotional lifestyle during residency that you will carry into practice. You will only be effective and satisfied as a family physician to the degree that you can find balance and fulfillment in the many roles you play.

Your time in residency training will be divided between the Family Practice Center, Mercy Medical Center, and community based opportunities. The majority of PGY1 clinical rotations are spent at Mercy Medical Center where you'll learn to function effectively in the in-patient environment. As you progress through your residency training, an increasing proportion of your time will be focused on the Family Practice Center and ambulatory rotations. Each week in the center you will build relationships with a growing panel of your own patients. Your patients will look to you for ongoing care and advice. Through these relationships you will learn to be a personal physician. Try to stop by the center every day if possible, to keep up with patient messages, prescription refill requests, etc. You'll know your patients better, be more help to the clinic staff, and everyone will get more satisfaction out of the relationship. Following your patients when they are hospitalized or when they deliver an infant is part of your education as well. While this can be a challenge at times, continuity of care is a foundation of family practice.

The family practice center is also actively involved in the training of primary care associates such as Family Nurse Practitioners and Physician's Assistants. This association of resident physicians and primary care associates gives you the opportunity to learn to function as a team member in an interdisciplinary approach to health care. Take advantage of it as the skills to function effectively as a team member/leader will likely be essential to your success as a modern physician.

The faculty is here to support you in your clinical care and professional growth. Family Physicians from the community (many of whom are program graduates) share the time as family practice preceptors as well. Many other physicians are actively involved in the Family Practice Residency Program as preceptors, guest lecturers and consultants. We welcome you to our community, look forward to working with you, and hope your experience offers both challenge and achievement.

OUR PARTNERSHIP IN LEARNING

Learning and teaching represents a partnership that is dynamic and challenging. Every person has their own background experiences, their “best” way to learn, and their “style” of teaching. At one moment the resident may be the learner, and at the next the teacher. Different teachers may have very different (and equally successful) methods for managing a particular clinical

problem. As a result, clear communication on needs and expectations will help the process along substantially. The full time and volunteer faculty teach because they want to, and the residents are here to develop in three short years the skills necessary to launch a successful career.

INSTITUTION MISSION STATEMENT, VISION, CORE VALUES STATEMENT OF COMMITMENT TO RESIDENCY PROGRAM



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November 13, 2017

I have reviewed and approve the ***Mission Statement, Vision, Core Values, and Statement of Commitment for the Mercy Redding Family Practice Residency Program*** previously developed by the Mercy Medical Center CEO, VPMA, and Family Medicine Residency Director and submitted and adopted by the Dignity Health North State Service Area Community Board of Directors on September 11, 2014.

Handwritten signature of G. Todd Smith in black ink.

G. Todd Smith, CEO
Mercy Medical Center Redding

Handwritten signature of James De Soto in black ink.

James De Soto, M.D., VPMA
Mercy Medical Center Redding & Dignity Health North State

Handwritten signature of Duane Bland in black ink.

Duane Bland, M.D., Program Director & DIO
Mercy Redding Family Practice Residency Program

Mission Statement, Vision, Core Values, and Statement of Commitment Mercy Medical Center Redding / Mercy Redding Family Practice Residency Program

Mission Statement

Dignity Health and its sponsoring congregations are committed to furthering the healing ministry of Jesus. Dignity Health dedicates its resources to:

- Delivering compassionate, high quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised;
- Partnering with others in the community to improve the quality of life.

Values

Dignity Health is committed to providing high-quality, affordable health care to the communities it serves. Above all else Dignity Health values:

- **Dignity** – respecting the inherent value and worth of each person.
- **Collaboration** – working together with people who support common values and vision to achieve shared goals.
- **Justice** – Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for those who are powerless.
- **Stewardship** – cultivating the resources entrusted to us to promote healing and wholeness.
- **Excellence** – Exceeding expectations through teamwork and innovation.

Vision

A growing and diversified healthcare ministry distinguished by excellent quality and committed to expanding access to those in need.

Values Integration

Our deep commitment and sense of purpose is rooted in the heritage, values and traditions of our healing ministry. The five core values of Dignity, Collaboration, Justice, Stewardship and Excellence serve as guides to help us demonstrate life-giving behaviors that are essential to carrying out our mission every day. Integration of values is comprised of the relationships, processes, and programs that are part of the fabric woven throughout our ministry to express the spirit and culture of Dignity Health. From routine to major decisions, our core values guide us in making moral, ethical and just decisions for the people we serve.

Statement of Commitment for Graduate Medical Education:

The Mercy Redding Family Practice Residency Program strives to graduate family physicians who are highly qualified to practice in rural and suburban areas, to provide care to the medically

underserved in our community and northern California, and to further the science and practice of family medicine through the application of information technology and management.

Mercy Medical Center Redding is committed to applying its mission, vision, and core values towards patient care and graduate medical education. We are committed to providing appropriate clinical experiences and effective supervision and teaching to achieve the highest level of competency. Mercy Medical Center will provide the necessary educational, financial and human resources to support graduate medical education in family medicine. We are committed to ensuring that resources are made available to ensure the compliance with ACGME requirements for its graduate medical education training. In the event of a disaster other event resulting in the interruption in patient care and resident education, Mercy Medical Center will provide assistance for continuation of resident assignments and education. If Mercy Medical Center decides to reduce or close the residency program, the following will be notified as soon as possible: the graduate medical education committee, the DIO, the Program Director, and the residents. In such circumstances, residents already in the program will be allowed to complete their education or assistance will be provided in enrolling in an ACGME-accredited program in which they can continue their education.

Mark Korth, CEO
Mercy Medical Center Redding

James De Soto, M.D., VP Medical Affairs
Mercy Medical Center Redding

Duane Bland, M.D., Program Director and DIO
Mercy Redding Family Practice Residency Program

**RESOLUTION OF THE
DIGNITY HEALTH NORTH STATE SERVICE AREA COMMUNITY
BOARD OF DIRECTORS
Residency Program Mission Statement and
Statement of Commitment**

WHEREAS, Mercy Medical Center Redding (“MMCR”) operates a family medicine program (the “Mercy Redding Family Practice Residency Program” or “Residency Program”) under an affiliation agreement with University of California Davis School of Medicine and is accredited by the American College of Graduate Medical Education (“ACGME”); and

WHEREAS, the Residency Program has developed a Mission Statement and Statement of Commitment that articulates the mission, vision and core values for Residency Program’s graduate medical education that is consistent with ACGME requirements and which is attached herein as Attachment A (“Mission Statement, Vision, Core Values and Statement of Commitment” or “Mission Statement”); and

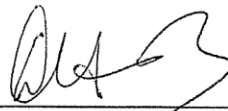
WHEREAS, the North State Service Area Community Board of Directors has determined that the attached Mission Statement as promulgated by the Residency Program and approved by MMCR, is appropriate and consistent with the North State Service Area hospitals’ mission;

NOW, THEREFORE, BE IT RESOLVED, that, the Mission Statement is hereby approved effective immediately.

CERTIFICATE OF SECRETARY

I, the undersigned, certify that I am the presently appointed and acting Secretary of the North State Community Board of Directors, and that the foregoing Resolution was adopted at a meeting of the foregoing Board on September 11, 2014, at which a quorum was present, and is now in full force and effect.

IN WITNESS WHEREOF, I have subscribed my name on September 11, 2014.



Douglas Hatter, M.D.
Board Secretary

CURRICULUM

Mercy Redding Family Practice Residency Program Block Diagram

PGY 1

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 3	Site 3	Site 3	n/a
Rotation Name	Med	Med	Med	NFM/NFOBP	OB	OB/Peds	Peds	ER	ICU/NFOR	Surg	Ortho	BSC/CM	Vac
% Outpatient													
Continuity	10%	10%	10%	0%	10%	10%	10%	20%	10%/0	20%	20%	10%/20%	n/a

PGY 2

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1/3	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2/3	Site 3	Site 3	Site 3	n/a
Rotation Name	Med	Med/Ortho	OB	Peds	NFM/NFOBP	C1	C2	C2	Outpt Ped	AwE/ABFM & Rad	Elect	Rural	Vac
% Outpatient													
Continuity	20%	20%/40%	20%	20%	10%	35%	30%	30%	30%	0%/30%	20%	20%	n/a

PGY 3

Block	1	2	3	4	5	6	7	8	9	10	11	12	13
Site	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 1	Site 2/3	Site 2/3	Site 3	Site 3/2	Site 3	n/a
Rotation Name	NFM/NFOBP	OB/Peds	ER	FPS	FPS/ICU	C1	Flex	EUOC	EUOC/Ortho	Elect	Elect/ UrgC	AwE	Vac
% Outpatient													
Continuity	10%	30%	20%	25%	25%/50%	30%	30%	50%	50%	40%	40%/30%	0%	n/a

Site 1- MMCR

Site 2- SCHC

Site 3- Offices

ABFM & Rad = American Board of Family Medicine Modules and Radiology

AwE = Away Elective

BSC = Behavioral Science

C1 = Outpatient Speciality Clinics 1

C2 = Outpatient Speciality Clinics 2

CM - Community Medicine

Elect = Elective

ER = Emergency Medicine

Flex = Flexible (C1, FPS, Med, NFM, NFOBP, OB, Elect)

FPS = Family Practice Service

ICU = Intensive Care Unit

Med = Internal Medicine Service Inpatient

NFM = Night Float Medicine

NFOBP = Night Float Obstetrics and Pediatrics

NFOR = Night Float Orientation

OB = Obstetrical Service Inpatient

Ortho = Orthopedics and Musculoskeletal Medicine

Peds = Pediatric Service Inpatient

Outpt Peds = Outpatient Pediatric Clinic

Rural = Rural Rotation

Surg = Surgery

UrgC = Urgent Care

Vac = Vacation

Note: Residents have 2 wks of orientation prior to Block 1 of PGY 1 year

CURRICULUM RESOURCES

The residency program has a variety of educational resources including the hospital library (journals and textbooks), Mercy Family Health Center library (outpatient oriented textbooks), UpToDate on-line, and Clinical Key on-line (textbooks, journals, and multimedia). The residency program also subscribes to Family Medicine Residency Curriculum Resource which can be accessed at www.fammedrcr.com using the residency password.

II. Clinical Rotations and Experiences

ADVANCED LIFE SUPPORT TRAINING (PGY1, PGY2, PGY3)

Core Competencies

At the completion of residency training, a family medicine resident should:

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)
- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)
- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns. (Practice-based Learning and Improvement)
- Appropriately inform, educate, and elicit patient and family participation in medical decision making in a professional and caring manner with sensitivity to cultural and ethnic diversity. (Professionalism, Interpersonal and Communication Skills)

Residents are required to maintain certification in NRP and PALS, Cardiopulmonary Resuscitation (Basic Life Support) and Advanced Cardiac Life Support (ACLS) all of which are completed during orientation. Re-certifications are required at the end of the R-2 year and can be taken at Mercy (Plan ahead for this). Advanced Trauma Life Support (ATLS) is an excellent intensive course, which is required for any resident who is licensed and who wishes to moonlight at a rural/remote ED in California. ATLS courses are available but often hard to schedule, so planning ahead is very important. The residency program will pay for the course registration, but all other costs are the resident's. Finally, ALSO courses are provided through the UC Davis Network, and all residents are encouraged to attend. Beginning in 2011, all PGY1 residents will be required to attend.

BEHAVIORAL SCIENCE (PGY1, PGY2, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Understand normal and abnormal psychosocial growth and development across the life cycle and be able to apply this knowledge to the care of the individual patient. (Medical Knowledge, Patient Care)
- Be able to recognize, initiate treatment for, and utilize appropriate referrals for mental health disorders to optimize patient care. (Systems-based Practice, Practice based Learning and Improvement)
- Demonstrate the ability to effectively interview and evaluate patients for mental health disorders using appropriate techniques and skills to enhance the doctor patient relationship. (Interpersonal and Communication Skills, Patient Care)
- Have sensitivity to and knowledge of the emotional aspects of organic illness. (Patient Care, Professionalism)

- Be able to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations. (Professionalism, Systems-based Practice)
- Understand the impact of mental health disorders on the family unit.

B. Service Goals

The primary objective of the Behavioral Science Curriculum is to help Family Practice Residents more fully develop the skills and the knowledge base needed to intervene meaningfully and efficiently in the mental health issues of patients. A large percentage of patients seeking ambulatory care have a psychosocial or cultural issue of significance that if unrecognized or mismanaged seriously impairs the effectiveness of the physician's care. Residents are expected to achieve the full set of Behavioral Science and Psychiatry Competencies through this curriculum. Curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

A two-week rotation occurs in the first year, and includes a variety of elements of behavioral medicine, psychiatry and psychopharmacology. Two half-days per month are allocated for to an ongoing "special clinic" devoted to psychiatry which occurs throughout the year and residents will rotate individually through this clinic at the Mercy Family Health Center (viz., FPC). In addition to the specific first year curriculum and the special clinic, behavioral science is integrated into the entire three-year experience at the FPC, in lectures, hospital rounds, clinic "shadowing", "curbside" consulting, and when requested, through elective experiences. During the first year, periodic site visits may be conducted to vital community agencies and mental health programs. This will provide residents with practice in networking within a mental health community and will provide them with referral and consultation resources. Some aspects of behavioral health training can be best implemented in an experiential manner including Counseling Skills Training, Interviewing Skills Training, Relaxation and Stress Management (for both residents and significant others), psychological testing and behavioral science precepting.

D. Duties

During the first year rotation, the Resident will spend face-to-face time with mental health professionals and patients in relevant facilities and agencies, and will undergo the various experiential training activities, as described above. Each Resident will have the opportunity to observe and experience the paradigm differences and similarities between the mental health field and the medical arenas to which they have become accustomed. Orientation to a range of mental health disciplines (e.g., psychiatry, clinical psychology, marriage and family therapy, etc.) will typically take place. Residents will also serve as observers or co-therapists, as indicated, in psychotherapy and counseling sessions. Whenever possible, this will encompass a range of therapeutic modalities, including individual, group, couples, and family, depending upon the availability of cases and

resources. Every effort will be made to orient Residents to community referral resources and relevant mental health legal issues.

Residents will be given the opportunity to sit in with and assist practicing psychiatrists as they meet with patients in community settings. This will not only provide valuable role modeling, but will provide practical and focused training in the use of psychotropic medication. Integration of Behavioral Science with general clinic-based outpatient medicine will occur during the rotation (and also during the second and third years of training) through precepting in which Behavioral Science faculty will see patients along with Residents during typical clinic visits. During the course of the first year rotation, the Resident will have regular contact with the Behavioral Science Coordinator who will provide supervision and will help the Resident process and integrate his/her experiences in therapy, intakes and with other professionals and agencies. Each Resident will be evaluated by the Behavioral Science Coordinator with respect to his/her competencies in this domain. Each mental health professional with whom the Resident came into contact during the rotation will also have an opportunity to provide feedback about the Resident. The Resident will also be given feedback and an oral review during a closure session with the Behavioral Science Coordinator.

Priority for the psychiatry “special clinic” at the FPC will be given to second and third year residents whenever the clinic schedule permits. This is because, for the most part, it will be a more advanced experience designed to assist residents in learning to provide independent, primary care level psychiatric services. However, when a first year resident is assigned to this training experience, teaching will be focused and guided toward the residents’ level of training and experience. The special psychiatry clinic is an important training opportunity for all residents inasmuch as Family physicians are frequently called upon to provide initial psychiatric screening and treatment in both inpatient and outpatient settings. They are also frequently required to provide longitudinal psychotropic medication management for patients whose primary clinical issues are psychiatric and yet are not severe enough that a referral to a psychiatrist is mandated. Accordingly, it is essential for residents to gain experience in handling this level of primary care independently. Services will mostly involve psychotropic medication management, but there will be elements of psychotherapy and counseling, crisis intervention, and coordination of special referrals. The focus of teaching with these cases will be appropriate for primary care physicians, resulting in a better integration of general medicine and psychiatry.

CARDIOLOGY (PGY1, PGY2, PGY3)

A. Competencies

At the completion of residency training, a family medicine resident should:

- Understand basic and clinical knowledge of cardiac anatomy and pathophysiology of common cardiovascular diseases. (Medical Knowledge)

- Perform an appropriate cardiac history and physical examination, document findings, develop an appropriate differential diagnosis, and plan for further evaluation and management. (Patient Care, Medical Knowledge, Interpersonal and Communication Skills)
- Use evidence based knowledge regarding primary and secondary prevention of cardiovascular disease. (Medical Knowledge, Patient Care)
- Review current practices regarding the care of patients with cardiovascular disease and develop plans to improve the care. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Professionalism)
- Work with physicians, nurses, pharmacists, dieticians, and other health care professionals who care for patients with common cardiovascular diseases. (Patient Care, Medical Knowledge, Professionalism, Systems-based Practice)

B. Service Goals

The goal of this experience is to prepare a resident to enter practice with the knowledge, attitudes, and skills to effectively evaluate, manage, and treat patients with cardiac conditions. Residents will also learn when to seek consultation appropriately. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

Cardiology is incorporated into the six week EUOC rotation. This experience is designed to expose residents to the evaluation and management of common cardiac conditions that present in the ambulatory and inpatient settings. The experience is based in a cardiologist's office practice and hospital with case based one on one teaching. Where appropriate to accomplish educational goals, residents may accompany cardiology preceptors into the hospital setting to consult on hospitalized patients. This rotation represents one component of a resident's training in cardiology. Substantial training in the primary care of patients with cardiac conditions is received in the Family Practice Center and during time spent on the inpatient medicine service. Responsibility for the medical management of inpatients with cardiac conditions occurs throughout residency training.

D. Duties

Attendance at the cardiologist's office and hospital is scheduled. During this time you will work one on one with the cardiologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/weeks.

CLINIC I and CLINIC II ROTATIONS (PGY2, PGY3)

A. Service Goals

The Clinic I and Clinic II Rotations are unique and valuable sets of ambulatory family practice and specialty experiences scheduled at MFHC and SCHC. The general goal is to provide the resident with a hands-on, longitudinal experience in various specialty areas (Allergy, Colposcopy, Dermatology, ENT, Family & Community Medicine, GYN, HIV, and Orthopedics) as defined below under the supervision of the relevant attending. The resident also develops a higher level of involvement and responsibility for the daily operations of the FHC, seeing acute add-on patients, participating in office management, ancillary services, review of patient care studies, and process improvement. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

B. Service Description

The Clinic I (C1) rotations generally occur once in the PGY II and PGY III years. The Clinic II (C2) rotation occurs twice in the PGY II year. See the Specialty Clinic descriptions under section D, which indicate the rotation (C1 and/or C2), site -- at the MFHC, SCHC or other site). Each month, the C1 & C2 clinic schedule may vary slightly, so the resident must consult the published schedule.

C. Duties

During this rotation the resident will be in clinic from 8:00 a.m. to 5:00 p.m. daily, Monday - Friday. The resident will be responsible for all specialty clinics as scheduled. They are also responsible for follow-up on all patients seen in specialty clinics during their month of clinic rotation.

When not scheduled for a specialty clinic, the resident will see his/her continuity patients and/or work-ins. Following call, the resident will have the day off (but call must be scheduled so that required specialty clinics are covered). Other health center responsibilities vary according to the Track and may include checking the Cerner EHR messages, labs, and prescription refills of those residents on away electives, night float, and vacation. Check with our FPC.

D. Specialty Clinics

During Clinic I and II rotations, time is scheduled in the specialty clinics held either at Mercy Family Health Center or Shasta Community Health Center. Continuity clinic time is maintained throughout the rotation at the minimum of three half-days/week.

Clinic I Specialty Clinic Monthly Frequency

Allergy:	1x
Dermatology:	1x
HIV:	1x

Practice Management	2x
Minor Surgery/Plastics:	3x
Vasectomy:	3x
Ortho Sports Medicine	1x
<u>Clinic II Specialty Clinic Monthly Frequency</u>	
Behavioral Science:	2x
Colposcopy:	5x
Dermatology:	1x
GYN:	2x

Allergy Clinic (C1 – MFHC):

Core Competencies

At the completion of residency training, a family medicine resident should:

- Be able to demonstrate knowledge of the diagnosis, treatment, and prevention of allergic and immunologic conditions, including but not limited to rhinitis, asthma, urticaria, anaphylaxis, immunodeficiency, and hypersensitivity reactions. (Medical Knowledge)
- Be familiar with the performance and interpretation of spirometry and skin testing. (Patient Care)
- Be able to discuss diagnostic, therapeutic, and preventive strategies of allergic and immunologic conditions with the patient and his or her family in a compassionate, effective manner. (Interpersonal and Communication Skills)
- Demonstrate respect and sensitivity to patients and their families. (Professionalism)
- Be familiar with the appropriate application of evidence-based guidelines regarding allergic and immunologic conditions. (Practice-based Learning and Improvement)
- Appropriately utilize allergy and immunology consultation and be familiar with established reporting processes for allergies and allergic reactions. (System-based Practice)

You will be working with Dr. Renard, an internist specializing in allergy/clinical immunology. During this outpatient rotation, the resident will gain experience in the recognition and proper management of common allergic problems and procedures. The resident must be present in the allergy clinic at all times during this rotation. The resident does an initial history and examination, and then presents them to the allergist to discuss management and strategy. Attendance at any allergy lectures during this rotation is mandatory. Upon completion of the allergy rotation, a short, written or verbal test is optional pending the discretion of the allergist.

Behavioral Science (C2 – MFHC)

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Understand normal and abnormal psychosocial growth and development across the life cycle and be able to apply this knowledge to the care of the individual patient. (Medical Knowledge, Patient Care)
- Be able to recognize, initiate treatment for, and utilize appropriate referrals for mental health disorders to optimize patient care. (Systems-based Practice, Practice based Learning and Improvement)
- Demonstrate the ability to effectively interview and evaluate patients for mental health disorders using appropriate techniques and skills to enhance the doctor patient relationship. (Interpersonal and Communication Skills, Patient Care)
- Have sensitivity to and knowledge of the emotional aspects of organic illness. (Patient Care, Professionalism)
- Be able to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations. (Professionalism, Systems-based Practice)
- Understand the impact of mental health disorders on the family unit.

This involves seeing mental health patients with Dr. Pappas

Colposcopy Clinics (C2 – MFHC and SCHC):

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling, based on the patient's age and risk factors. (Patient Care, Medical Knowledge)
- Be able to perform routine gynecological procedures (Patient Care, Medical Knowledge)
- Develop treatment plans for common conditions affecting female patients, including reproductive issues, utilizing community resources when

indicated. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)

- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women. (Patient Care, Interpersonal and Communication Skills)
- Consult with obstetrician-gynecologists, other physician specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice)

Training is provided in the management of abnormal cervical pathology under the supervision of family practice faculty. Procedures include Colposcopy, cryotherapy and LEEP. Colposcopy clinic is held four times per month at Shasta Community Health Center and once each month at Mercy Family Health Center. Residents may also be scheduled at Mercy Maternity Clinic as the schedule allows.

Dermatology Clinic (C1 and C2 – MFHC):

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Provide compassionate and culturally appropriate patient care that recognizes the effect of skin problems on the patient and emphasizes the importance of comprehensive preventative care. (Patient Care)
- Be proficient in the diagnosis and treatment of common dermatologic diseases and be adept at performing common dermatologic procedures. (Medical Knowledge)
- Utilize diagnostic and evidence-based treatment guidelines as well as maintain up-to-date knowledge of appropriate usage of evolving dermatologic treatment technology. (Practice-based Learning, Improvement)
- Demonstrate the ability to communicate effectively with the patient so that dermatologic diagnosis and treatment is provided in a non-judgmental, caring manner. (Interpersonal Communications, Professionalism)
- Incorporate knowledge of the dermatology specialty in order to determine which problems can be managed by a family physician and to understand how to coordinate needed referrals to specialty providers. (Systems-based Practice)

During this outpatient rotation the resident will gain experience in recognition and proper management of common dermatological problems and minor dermatological surgical procedures. This rotation is a “hands-on” experience that depends on the residents to provide direct care, so residents must be present in the dermatology clinic at all times during this rotation. The residents see patients and present them to the dermatologist, discuss management and strategy. All extensive surgical procedures are referred to the Lumps and Bumps Clinic. The resident on Dermatology does biopsies while excisions are referred to the Minor Surgery Clinic.

GYN Clinic (C2 – MFHC and SCHC):

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling, based on the patient’s age and risk factors. (Patient Care, Medical Knowledge)
- Be able to perform routine gynecological procedures (Patient Care, Medical Knowledge)
- Develop treatment plans for common conditions affecting female patients, including reproductive issues, utilizing community resources when indicated. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women. (Patient Care, Interpersonal and Communication Skills)
- Consult with obstetrician-gynecologists, other physician specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice)

You will be working with community gynecologists at MFHC, SCHC and private gynecologists’ offices approximately 15 half-days/month developing appropriate experience in, recognition of, and proper management of common GYN problems and procedures. The resident will see patients and present them to the gynecologist as appropriate to discuss diagnosis and management. GYN surgical patients from the MFHC GYN clinic will be followed on the family practice in-

patient service. The resident on C2 or the patients PCP should assist at the surgery with the GYN attending.

HIV Consultation Clinic (C1 – SCHC):

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Recognize HIV risk factors to actively counsel patients regarding primary and secondary prevention, risk reduction, testing, diagnosis, treatment, and management. (Medical Knowledge)
- Recognize the symptoms of acute retroviral syndrome and appropriately diagnose and treat HIV infection in this setting. (Medical Knowledge)
- Synthesize an appropriate diagnosis and management plan for conditions associated with HIV infection. (Patient Care & Medical Knowledge)
- Optimize treatment plans based on knowledge of local HIV care resources that include governmental and non-governmental agencies. (Medical Knowledge)
- Communicate effectively with patients to ensure a clear understanding of diagnosis and plan of care. (Interpersonal Communications)
- Recognize own practice limitations; seek consultation from other health care providers and resources to provide optimal patient care. (Professionalism, Systems-based Care)
- Understand the legal, ethical, and social context of HIV, and its impact on the care of special populations. It is especially important for the resident to understand forms of HIV stigma that exist in the community where they are working. (Professionalism)
- Recognize preventive care screening required for HIV positive patients and how this differs from recommendations for the general population. (Medical Knowledge)

This clinic is designed to promote resident and community understanding of the diagnosis and treatment of HIV disease and its complications. This clinic is conducted at SCHC and run by Drs. Coe, Dr. Miles, and Villalobos. The Resident participates in the work-up and management of HIV patients on a consultative basis developing their knowledge and skills in the management of HIV patients in their own practice.

Ortho Sports Medicine (C1-MFHC)

Core Competencies

At the completion of residency training, a family medicine resident should:

- Perform an appropriate musculoskeletal history and physical examination, and formulate an appropriate differential diagnosis and recommend treatment, including requisite subspecialty referrals (Patient Care, Medical Knowledge, Systems-based Practice)
- Perform an evidence-based, age-appropriate, and activity-specific pre-participation physical examination (Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism)
- Communicate effectively with a wide range of individuals regarding musculoskeletal health care, including patients, their families, coaches, school administrators, and employers (Interpersonal and Communication Skills)
- Understand that sports medicine involves caring for the medical conditions of athletes in addition to the musculoskeletal conditions (Patient Care)

Residents will work with Tony Chang, MD during the Ortho Sports Medicine at MFHC with referrals to the clinic coming from providers at MFHC.

Practice Management (C1 – Private office) Core Competencies:

At the completion of residency training, a family medicine resident should:

- Demonstrate physician leadership as an uncompromising advocate for patient-centered care of the highest value within the constraints of a viable and sustainable business model for the Patient-Centered Medical Home (PCMH), Patient-Centered Medical Neighborhood (PCMN), and the Health Home (Healthy Community) for the patient’s welfare while balancing the business realities of practice management and financial success. (Patient Care and Professionalism)
- Actively conduct a practice search, interviews, contract negotiations, and successfully enter practice. (Interpersonal and Communication Skills)
- Demonstrate knowledge of the legalities and ethics of hiring, promoting, and firing of employees in a practice setting. (Professionalism)
- Identify the structure and operations of health organizations and systems, and the role of the family physician in this structure. (Systems-based Practice)
- Identify the measures of health, including determinants of health, health indicators, and health disparities. Advocate for the development of value metrics which will optimize Meaningful Use reporting and payment for value in the healthcare system. (Practice Based Learning and Improvement)
- Identify and foster partnerships that maximize achievement of public health goals. (Systems-based Practice)

This rotation will be incorporated into the C1 rotation with two half days during the PGY2 year and two half days during the PGY3 year. It will take place at a private family physicians office in Redding. The experience will primarily focus on Practice Management, with opportunities to meet with the various office staff and physicians to learn how to provide patient care efficiently and effectively in a private practice setting. Residents will learn the following skills:

- Effective billing
- Designing a budget and managing overhead costs
- Collections for various insurance carriers
- Assessing practice staffing needs
- Understanding of office manager function
- Personnel management and labor issues
- Employment law and procedures
- Integrating new technologies into one's practice
- Determining value of patient care in one's community
- Assessing customer satisfaction
- Measuring clinical quality
- Tort liability and risk management
- Office scheduling systems
- Use of computers in practice
- Alternative practice models

Vasectomy Clinic (C1 – FPI)

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Be proficient in communicating in a sensitive and cogent manner with the patient and others involved in his care (when appropriate) all aspects of diagnosis and treatment. (Interpersonal and Communication Skills, Patient Care, Medical Knowledge)
- Be knowledgeable about local resources that are available to assist in assuring appropriate services to male patients. (System-based Practice, Patient Care)

Residents also participate in Vasectomy Clinic, which is incorporated into a procedure training clinic located at SCHC and precepted by family physicians. The goal is to have residents become proficient at performing vasectomies, and all aspects relating to the procedure, including counseling, pre-op exam, and post-op care.

COMMUNITY MEDICINE (PGY1)

A. Core Competencies

At the completion of residency training, a family medicine resident should be able to:

- Demonstrate an ability to work effectively with multicultural and impoverished patients/populations. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-based Practice)
- Define the needs of special populations in the suburban and rural setting. (Medical Knowledge, Systems-based Practice)
- Be knowledgeable in adapting the health delivery organization to the culture and the needs of the patients and community being served. (Practice-based Learning and Improvement, Systems-based Practice)
- Describe the epidemiological / demographic characteristics of the population being served. (Medical Knowledge)
- Be knowledgeable in improving and transforming patient services based on patient outcome data and self-assessment. (Practice-based Learning and Improvement)
- Explain how the social determinants of health contribute to health outcomes. (Medical Knowledge)
- Be knowledgeable in effecting health behavior change. (Medical Knowledge, Interpersonal and Communication Skills)
- Be knowledgeable in self-care practices that prevent burn out. (Professionalism)

B. Service Goals

Family physicians work predominantly in the ambulatory care environment and must have a strong understanding of the community and its resources for assisting in a patient and family's care. The family physician's role in providing health care to a community includes the application of medical knowledge to the care of various populations, school medicine, occupational medicine, epidemiology, health education, Home Care and Hospice, and public health. This rotation will also emphasize health care delivery issues unique to rural and remote locations in Far Northern California. Residents are expected to achieve the full set of defined Community Medicine Competencies during this rotation. Finally, additional and important longitudinal experiences are structured in the Family & Community Medicine rotation in the PGY II and PGY III years (see Clinic I and Clinic II). Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

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During this rotation, residents will be exposed to occupational health during their experiences at employee health at Mercy Medical Center. They may also work with the Ambulance Service at Mercy to understand the presentation and management of emergencies “in the field.”

Residents will also spend a day at the Shasta County Public Health Department. The following is a sample schedule:

8:00 am – 9:00 am	Introduction & Welcome – Overview of Public Health Donnell Ewert, MPH – Director of Public Health Terri Fields Hosler, RD, MPH – Deputy Director
9:00 am – 10: 00am	Outcomes, Planning & Evaluation Brandy Isola, MPH - Program Manager
10:00 am – 10:30 am	Domestic Violence & Perinatal Substance Abuse Romi Uribe, MCAH Director
10:30 am – 11:00 am	Child Health & Disability Prevention and PM160 Linda Reynolds, PHN – CHDP Deputy Director
12:00 pm – 2:00 pm	Public Health Advisory Board (PHAB)
2:00 pm – 3:30 pm	PHAB -Public Health Electives Communicable Disease Dave Maron, PHM, CLS – Program Manager Kate Thomas – Supervising Public Health Nurse
3:30 pm – 3:45 pm 3:45 pm – 4:30 pm	Preventative Medicine & Overview of Public Health Andrew Deckert, MD, MPH – Health Officer

Finally, the resident also has an “immersion” experience at the FPC for orientation and to appreciate their belonging to the model practice team.

D. Duties

Residents will attend various scheduled activities scheduled during community medicine rotation. Call scheduling should be avoided if possible during this rotation.

CONTINUITY HOME CARE VISITS (PGY2, PGY3)

Clinical Competencies:

At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)
- Be able to communicate effectively with patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for women, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women as well as comprehensive wellness counseling based on the patient’s age and risk factors. (Patient Care and Interpersonal and Communication Skills)
- Consult and communicate appropriately with obstetrician-gynecologists, maternal fetal medicine specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice, Professionalism)

- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood. (Interpersonal and Communications Skills)
- Recognize his or her practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

Goals:

The goals of performing continuity home care visits are to allow residents to see patients in their home environments and to identify social and/or environmental concerns which impact patients' ability to maximize their health/health care system. These visits will assist the resident in better understanding the obstacles to, as well as resources for, improving their patients' overall health and well-being.

Description:

Each resident must perform at least two home visits during his/her residency training, one of which must be an older adult continuity patient. It is recommended that the second be a 1-6 week post-partum mother-baby home visit for a Mercy Family Health Center (MFHC) continuity obstetric patient.

An addition, residents perform Adult Home Visits by seeing MFHC patients during a C1 Mission Provider Home Visits.

Duties:

Each resident will identify patients from his /her continuity clinic panel, who would be appropriate for, and accepting of, a home visit.

A faculty member must supervise all home care either on site (preferable) or by prompt chart review, as is appropriate based on a resident's level of expertise and competence. If a faculty member is unable to accompany the resident to the patient's home, it is recommended that he/she take another resident. Home Visit Packets with the appropriate forms documenting pertinent social/clinical information and education can be found in the MFHC Preceptor Room file. It is preferable that these visits be recorded on the forms provided, opposed to dictating, as this will ensure prompt chart reviews and verification/tracking of these educational experiences.

Completed home visit forms will be filed into the patients MFHC clinic record. Each home visit should also be entered by the resident into the New Innovations on-line tracking program.

Home Visit Instructions

- 1) Identify an appropriate patient for home visit and contact the patient to discuss the home visit, schedule a time, and get directions. Coordinate with a faculty member's schedule if he/she is to attend the home visit with you.
 - 2) Obtain the Home Visit Packet from MFHC Preceptor Room file prior to your scheduled visit.
 - a. Continuity Home Care Visit policy statement
 - b. Home Visit Instruction Sheet
 - c. Home Visit Record (Infant, Maternal, Geriatric)
 - d. CPSP Billing Sheet or Purple Nursing Facilities Billing Sheet
- 34) Enter the home visit in New Innovations

ENT (PGY3)

A. Core Competencies:

At the completion of residency training, a family medicine resident should:

- Be able to perform a surgical assessment and develop an appropriate treatment plan (Medical Knowledge, Patient Care)
- Coordinate ambulatory, inpatient, and institutional care across health care providers, institutions, and agencies (Systems-based Practice, Patient Care)
- Demonstrate the ability to communicate effectively with the patient, as well as with the patient's family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood (Interpersonal and Communication Skills)
- Demonstrate the ability to communicate effectively with the surgeon supervisor/consultant about the patient's symptoms, physical findings, test results, and proposed plan of care (Interpersonal and Communication Skills, Professionalism)
- Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care (Professionalism, Practice-based Learning and Improvement)

B. Service Goals

The goal of this rotation is to prepare a resident to enter practice with the knowledge, attitudes and skills to effectively evaluate, initiate management and, when appropriate, seek consultation on patients with more complex ENT conditions.

C. Service Description

The ENT rotation is integrated into a six week block in the third year of residency along with Urology, Cardiology, and Ophthalmology and is designed to expose residents to the evaluation and management of common ENT conditions that present in the ambulatory setting. The experience is based in an ENT office practice with case based, one on one teaching. Where appropriate to accomplish educational goals, residents may accompany ENT preceptors into the hospital setting to assist or observe surgical procedures. This rotation represents one component of a residents training in ENT. Substantial training in the primary care of patients with ENT conditions is received in the Family Practice Center. Responsibility for the medical management of inpatients with ENT complaints occurs throughout residency training.

D. Duties

Attendance at the ENTs office is scheduled. During this time you will work one –on-one with an ENT. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/week.

ELECTIVES (PGY2, PGY3)

A. Service Goals

Electives are primarily intended to enrich the residents’ training with experiences relevant to their future practice, their special interests, or for rounding out the training experience with competencies not attained through the required rotations. As adult learners responsible for their continuing medical education beyond residency, each resident must be able to identify educational opportunities and then craft experiences that will address those individual needs. The program supports and encourages this self-directed learning opportunity. Up to one month of elective time may be used for remediation, determined by the Residency Program Director.

B. Service Description

There are 16 weeks of elective time (6 of these weeks are away elective). . While on Elective, residents participate fully in their continuity health center duties, call, and conference attendance. If an Away Elective is approved by the Program Director, even if that time is taken locally, the resident has no health center, call or conference responsibilities, which nearly doubles the actual amount of time for the elective experience(s) during this Away Elective block. While we will make every attempt to accommodate resident requests for time away, that is not a guarantee, because of Medicare funding, and provision of continuity services to the residents’ patients at the FPC. International electives must meet the criteria below before they will be considered. Out of state electives will also require exceptional justification. Finally, Research Electives can be structured as a research or academic project, focused on a research or

evidence based literature clinical project resulting in a formal presentation at Grand Rounds.

C. Duties

The residency must comply with the regulations of both the Accreditation Council for Graduate Medical Education (ACGME) and Medicare for the appropriate approval and documentation of elective time. Without this documentation, credit cannot be given to the resident for the elective rotation. Further, the hospital will be in violation of its financial obligations to Medicare and cannot be paid the monies that support the residency program. **For these reasons, the Elective Form, which contains the required steps to obtain approval for the elective and document approval from the supervising physician, must be completed in its entirety. If the resident has not submitted the proper and completed Form to the Program Director (who approves each Elective) one month in advance at the latest (earlier for international electives – see below), the resident will be assigned to an in-patient rotation with the usual FPC duties.**

General Elective Procedure: (see Request for Elective form)

Section 1: The resident must identify the experience and develop educational objectives that describe what the resident seeks to learn in the experience.

Section 2: The resident must obtain the signature and other demographic information requested from the supervisor

Section 3: The resident must submit the Request for Elective form to the Residency Program Director for approval

- a. No later than one block in advance of the Away Elective
- b. No later than 3 ½ blocks in advance of international electives and electives if any special scheduling requests involving the health center or call are desired. If not, one block advance is sufficient.
- c. A copy of this form will be sent to the Chief Resident, the Health Center and the Resident

Section 4: The final evaluation must be completed by the supervisor for the resident to receive credit for the rotation. It is the resident's responsibility to have the supervisor complete Section 4 Final Evaluation and return this to the residency office.

Additional Criteria for Away Electives

Away electives require a CV from the preceptor and a description of the location (clinic) they will be working at (brochure or copy of web site preferable).

Additional Criteria for International Electives

- i. Resident is performing well in competency areas of patient care, medical knowledge, and practice based learning and improvement, interpersonal

communication, professionalism, systems based practice, procedural skills, and is functioning at a level appropriate to training. (Based on residents rotation evaluations, ITE scores, and academic counseling reports)

- ii. Faculty quality preceptor available on-site
- iii. Medical repatriation insurance is obtained and resident understands/accepts the limitations of CHW insurance policies (**Note: The AAFP has information on their website under International Travel and Health which includes links on travel information, insurance, etc.**)
- iv. Specific Rotation goals and objectives established ahead of time
- v. Fluency in native language or access to bona fide translator
- vi. Grand rounds caliber presentation on relevant clinical topic after return
- vii. Resident bears all costs of travel, housing, food, pre-health screenings and immunizations
- viii. Resident may be responsible for acquiring and paying their own separate malpractice insurance during the international rotation

Additional Requirements for Research Electives:

- Define the scope of the project and how it directly relates to the care of your patient(s) at Mercy Family Health Center
- Limit to 2 weeks per the span of residency training unless exceptional circumstances
- Schedule as Elective (addressing when resident will be in clinic). Research Electives will not be scheduled as “Away” electives unless the nature of the project requires the resident to be away from Redding. Requests for exceptions to this policy will be made on a case by case basis and reviewed by the residency office.
- Define how the resident plans to organize and present the material covered during the elective. Choices include:
 - Giving a noon conference or grand rounds (If a resident elects to give noon conference he must talk to Steve Namihias to schedule a day.)The presentation of the material covered in the research elective must ready at the completion of the designated elective time.
 - Summarizing the material in a written report and presenting it to the faculty advisor. The summary of the material must be ready for presentation at the completion of the designated elective time.

Additional Requirement for Site Visits (see also Management of Health Systems):

- Senior residents are allowed to take 3 days from their usual resident duties providing that any time off is arranged around their clinic schedule, as per the clinic scheduling policy.

- Time for spent evaluating a site beyond three days will be counted as PTO time. Of note, additional days away from the program may result in an extension of residency training and a delayed graduation. If the resident thinks he/she will need additional interview days, it is recommend that elective rotation days be scheduled during a portion of the regularly scheduled vacation weeks. This will allow upcoming vacation days to be used for interviews.
- The resident must fill out an elective rotation application form prior to this activity and have it signed by the program director.
- This is considered an educational opportunity in the area of practice management; the resident must complete a practice site evaluation form (available in residency office). The supervisor at the practice site who provides the information about the site must sign and date the form.

EMERGENCY MEDICINE (PGY1, PGY2, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)
- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)
- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns. (Practice-based Learning and Improvement)
- Appropriately inform, educate, and elicit patient and family participation in medical decision making in a professional and caring manner with sensitivity to cultural and ethnic diversity. (Professionalism, Interpersonal and Communication Skills)

B. Service Goals

The goal of this rotation is to develop the skill in the assessment and management of acute

medical and surgical disease entities in the emergency department setting. This rotation will allow the resident to better see things from the perspective of an ED physician, which is different from continuity of care outpatient medicine. In the ED, all patients are evaluated rapidly yet thoroughly and in some cases may be seen as having the worst possible diagnosis until that diagnosis is “ruled-out”. In many cases, patients who do not have a clear diagnosis must be admitted for further evaluation.

By the end of the rotation, residents will be able to triage many patients within a few minutes regarding the need for admission. Residents will be encouraged to evaluate and manage an increasing number of acute medical and surgical patients simultaneously. The goal for a first year resident is 1 to 2 patients at a time, then 2 to 3 as a second year, and 3 to 4 as a third year. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

As required by the ACGME, residents receive over 200 hour’s emergency medicine training. The rotation is broken up into two separate two-week rotations in the intern year and 4 weeks in the third year. The ED physicians are all partners with California Emergency Physicians America (CEP) and work at both Mercy Medical Center Redding and St. Elizabeth’s in Red Bluff. The hospitals are considerably different and provide varied opportunities for learning. St. Elizabeth is a small community hospital that has a significant migrant worker population and limited subspecialty resources, while Mercy is a Level II trauma center with many subspecialties that draw people from the entire north state.

The amount of time residents will be scheduled in the ED will vary by resident year, due to differences in call and continuity clinic time. R1s will be scheduled for a goal of **40-48 hrs. /wk.** (10-12 hour shifts) per week, R2s will work a minimum of **34 hrs. /wk.** (68 hrs. over the two week rotation) and R3s will be scheduled a minimum of **30 hrs. /wk.** (120 hrs. over the four week rotation). Residents will work a minimum of 24 hours at St. Elizabeth’s Hospital in Red Bluff during a 4-week rotation and no less than 12 hours for a 2-week rotation. Residents will have off all post-call days. Residents will be scheduled, as much as possible in morning clinic at MFHC and will avoid having EM training interrupted by noon conference or clinic. Preceptor shifts at both Mercy and St. E’s may fluctuate but will be accommodating. There will be flexibility for scheduling shifts but for the most part, they should coincide with an oncoming doctor’s shift with a minimum of 8 consecutive hours to maximize patient care continuity and work flow. Resident’s schedules will be made by Dr. Rawlings and approved by the residency office to accommodate their clinic and call schedules, and the best attempts will be made to schedule them on the higher acuity shifts and variety spanning early morning until late evenings and occasionally night shifts. Shifts will generally be 10-12 hours in length which is mostly due to the rules on residency work hours to protect the required number of days off and time off between shifts. If you see any violation of these rules, please bring that to the attention of Dr. Rawlings or Dr. Bland so we can make adjustments. Some shifts may be shorter in hours if the need arises. If two residents are scheduled for the ED rotation during the same block (usually and intern and third year), they cannot be scheduled in the same ED during the same shift but may be allowed to overlap. Residents will be assigned to a specific Preceptor Physician

on the schedule, but in practice, while on shift a resident may see a patient with any Preceptor Physicians if they are part of the volunteer clinical faculty (VCF) pool. Understand that near shift change, it makes sense to staff the case with the Attending Preceptor that will be staying or newly arrived.

Look and ask to get involved with higher acuity cases, traumas, procedures, and other interesting cases. Please introduce yourself to the physicians as you meet them and let them know you are working that day and what times. R2s may spend up to eight hours in the pre-hospital arena to develop an understanding of the challenges in the field. (Air Ambulance exposure is excluded due to liability problems, but if you would like to have this experience please speak with Dr. Rawlings to schedule something outside of the residency requirements). Attending Preceptors ED can provide supervision, but not mid-level providers.

Luke Rawlings, MD will coordinate the ED rotation and manage the schedule. He is available at Mercy ED, his cell is 805-708-0933, email: lukerawlings@cep.com Scheduling issues should be worked out at least 2 weeks before the beginning of the ED rotation. Please contact him directly to initiate this. There will be a brief orientation before the rotation starts.

Although residents may be excused to attend noon conference, that hour does not count toward the total time expected for the ED. Residents must inform the ED attending when leaving and returning to the ED. Before leaving, residents must also inform the ED attending of their action plan for each patient, including test results pending, written instructions, and prescriptions if needed.

During the rotation, you will be expected to meet with Dr. Rawlings that will be used for didactic topics, emergency medicine skills, and case presentations. Residents, medical students and others rotating in the department will be expected to bring interesting cases they have encountered to briefly present and discuss.

Tuesday Trauma Rounds in the ICU (8-9 am) does count towards the total expected ED clinical time. Although they do not count towards the ED hour requirements above, they will be factored into the self-directed learning part of the evaluation.

If the rotation coincides, residents are also encouraged to attend the Emergency Medicine Journal Club. The EM journal club is scheduled on a quarterly basis.

Bring your ED rotation folder with you to the shift or leave it in the ED during, so you can have something to read or reference and also other ED Attendings may want to refer to it or assign a reading.

D. Duties / Faculty Expectations:

To maximize learning opportunities, residents should preference and find new cases of higher acuity or procedure-requiring and ask their Preceptor for advice as needed. Residents should be alert for codes or patients arriving by ambulance, helicopter, or being brought straight back from

triage since most critical patients offer good learning opportunities. These cases must be discussed with the ED attending prior to ordering therapeutic and diagnostic interventions. Although, residents will be granted greater autonomy with additional experience, part of the educational benefit comes from learning how an experienced ED physician approaches clinical problems. Unstable patients may require resuscitation prior to obtaining the entire H&P and diagnostic studies. Residents may observe codes, but are encouraged to participate, as they feel comfortable, particularly intubations or other procedures. If residents are aware of a specific experience for which they need additional training, they are encouraged to inform the attending at the beginning of the shift so the attending can direct the resident to those patients or discuss with Dr. Rawlings.

Residents are expected to be available to see patients during their entire shift and encouraged to ask as many questions as needed. They must notify the ED staff when leaving the department for any reason.

Residents will be evaluated on the following:

Patient care- which includes gathering essential and accurate history and physical exam data, ordering appropriate tests, integrating medical facts with clinical data, formulating logical plans, and documenting appropriately. Residents must present cases in a concise, logical, structured, appropriate manner. Residents must see a minimum number of patients per shift according to year of training: 0.5 patients per hour for R1s, 0.8 patients per hour for R2s, 1 patient per hour for R3s. (e.g., In a 10 hour shift, R1s will see a minimum of 5 patients, R2s 8 patients, and R3s 10 patients). These are minimum numbers with the expectation that residents will see more.

1. To keep track of total numbers of patients seen, residents should keep a paper with the stickers of the patients they see and the diagnoses they encountered. If more than one diagnosis was addressed, please document and include any procedures performed. Bring these to your meeting with Dr. Rawlings. There is a simple form for this purpose, which is included in the rotation folder. Residents will also give Stacy Brewen a copy and the resident will hold on to the original for their own record. This will likely be needed to track patient numbers for residency requirements.
2. Medical knowledge- which includes formulating extensive differential diagnoses for all patient problems, integrating biopsychosocial factors, and applying evidence-based medicine. Residents will be encouraged to see patients throughout their rotation to get exposure to the broad curriculum of emergency medicine. A curriculum list will be included in your rotation folder for your reference. Reading topics have been included in the rotation folder also. While they all are not required, they are strongly suggested. Please feel free to use the books and resources in the ED and online about cases you have encountered or other topics or skills. The text book where most of the readings are derived is, Harwood-Nuss's "Clinical Practice of Emergency Medicine" Fifth Edition, 2010. Others are from, Roberts and Hedges "Clinical Procedures in Emergency Medicine" Fifth Edition 2010 and Tintinalli's "Emergency Medicine: A comprehensive Study Guide" Seventh Edition 2010. A variety of other sources are included.
3. Procedural skills- with attention to proficiency, patient comfort and safety. Noon conferences for EM occur once a month (on the third Monday from 12:30 to 1:30 in conference room AB. Periodic skills sessions will be scheduled for individuals and for the entire resident

class throughout the year. Topics will include procedure training. Residents will be expected to visit PHI Aeromedical Transport headquarters for training in Airway management or on-site at Mercy.

4. Self-directed learning- including self-initiative, asking for assistance and consults appropriately, accepting criticism, and applying new information.
5. Interpersonal and communication skills- including effective and appropriate communication with nurses, ED Attending, peers, consultants, patients, and families.
6. Professionalism- relating with staff and patients in a responsible, ethical, empathic, compassionate, and trustworthy manner.
7. Systems based practice- uses all care resources and ancillary care providers appropriately.

E. ED Organization:

Patient flow: a triage nurse and Provider (Physician Assistant, Nurse Practitioner, or Physician) will first see all patients arriving to the ED through the lobby entrance. This will occur in the triage area if there are no beds available to be brought back immediately. A brief history will be taken, limited physical exam, and vitals will be done. The patient disposition may sometimes be made directly from there, and other times the provider will start the work-up and treatment while the patient awaits bedding in the main emergency department or the ED Annex. When a bed is available, the patients chart will then be put in the main ED rack. Seriously ill patients will be taken back immediately to a bed. Be aware of the ED FirstNet Tracking Board for new patients, as the chart may be delayed before it comes to the rack. Before going to see the patient, please make the attending aware you are taking the chart from the rack and will see the patient in a timely manner. This helps to avoid confusion as to where you may be and the location of the medical chart. Residents will want to see those patients who appear challenging and unusual. Many orthopedic injuries and lacerations, which may be of interest to residents, are triaged to the Rapid Access Wing (Rawhide) area. These patients, however, must be staffed with the ED attending and not the mid-level providers, so please make the Attending aware and the Midlevel provider aware of your interest.

Referral/Transfer Calls: Residents may not accept these phone calls even if asked to do so by the nurses (if the ED Preceptors are busy). Most of the nurses know this. But if asked, residents must decline taking the call.

Documentation: Residents must document their findings on the paper chart and consider (discuss with attending) dictating a note, including the name of the supervising attending physician. Dictation will be rare, but good documentation will be expected and Dr. Rawlings will review the documentation before the rotation. Residents, who participate in resuscitations or assist with procedures but are not primarily involved with the care of that patient, will not be expected to dictate. If a resident performs a procedure entirely, he should check with the supervising attending to clarify who will dictate the procedure note. With the introduction of the Electronic Medical Record, the documentation requirements will be changing.

F. Emergency Medicine Knowledge and Skill Competencies:

1. Knowledge:

- Assessment, resuscitation & stabilization of critically ill patients (including codes)
- Chest Pain (AMI, ACS, PE, aneurysm, arrhythmias)
- Respiratory Distress (asthma, COPD, foreign body, pneumonia, CHF)
- Abdominal Pain (peritonitis, AAA, renal calculi, gallbladder disease, appendicitis, mesenteric ischemia, hernia)
- ALOC (toxic, metabolic, infectious, trauma)
- Neurological Deficit (CVA, TIA, peripheral deficits, e.g. Bell's palsy or w/LBP)
- Vaginal Bleeding (ectopic, first trimester bleed, DUB, ovarian cyst/torsion)
- Pediatric Fever (how kids are different, ED w/u, 1st 1-3 months)
- Headache/Back pain (CNS bleed, meningitis, pain management)
- Trauma (general assessment, orthopedic and soft tissue injuries)

2. Skills:

Efficient patient evaluation & disposition (directed H&P, testing, communication with physicians, f/u, and multiple patients.)

Airway/ Breathing (intubations, non-invasive adjuvant, ventilator, meds)

Circulation (access lines, cardioversion, vasopressors, monitoring)

Conscious Sedation/ Pain Management (indications, meds, monitoring)

Orthopedic interventions (immobilization, reductions)

Wound care (infiltration, blocks, irrigation, laceration repairs, bites, I&D)

Eye procedures (slit lamp exam, FB removal, tonometry)

ENT procedures (nasal cautery/packing, peritonsillar abscess, dental blocks, FB removal)

Miscellaneous (use & interpretation of x-ray, LPs, urinary caths, NG/Ewald, lavage, anoscopy)

Emergency Medicine Rotation Requirements

_____ Contact Dr. Rawlings at least 1 week before the start of your rotation to set up an orientation (usually 30-45 minutes) before starting your first shift.

_____ Keep a log of your patients, diagnosis/problems, procedures on daily ED patient log provided in ED rotation folder or in similar manner. Your residency department may need these in the future to evaluate your patient numbers. Dr. Rawlings will review some of the cases with you and you will need these daily patient logs to complete the ED rotation curriculum table. This will help us track what residents are seeing/doing in the ED and improve their exposure/experiences for future residents.

_____ Using an interesting or challenging patient case you were involved with in the ED, read an emergency medicine textbook chapter on it and/or other literature and be able to give a 10-15 min discussion of the case and teaching points you have learned in the readings. You will have this brief presentation/discussion with Dr. Rawlings, and preferably at a future resident morning report with your peers.

_____ Pre-read about airway management and then practice the airway management skills at the PHI Aeromedical base. This will be done usually with Dr. Rawlings and an aeromedical Flight Nurse or Paramedic crew member.

Comments:

Signed: _____ Date: _____
 Luke Rawlings, MD

Cc: Duane Bland, MD, Residency Director

THE FAMILY PRACTICE CENTER

See Section IV: ADDENDUM: MERCY FAMILY HEALTH CENTER CLINIC MANUAL

HOME VISITS

Each resident is to make at least two home visits over the course of training. One of these is to be a newborn visit and the other is an older adult. Dr. Clint Evans coordinates the newborn visits; Dr. Nena Perry coordinates the older adult visits. The appropriate form is available in the preceptor room and is to be completed by the resident during the visit. Please see Dr. Evans and/or Dr. Perry for further information. [The academic advisor for each resident will co-sign the Newborn home visit notes, unless the academic advisor is Nena Perry, in which case Clint Evans, DO will co-sign.](#)

FAMILY CENTER CONTINUITY OBSTETRICS EXPERIENCE

See Section IV: ADDENDUM: MERCY FAMILY HEALTH CENTER CLINIC MANUAL

FAMILY PRACTICE SERVICE (Inpatient/Outpatient Rotation) (PGY1)

A. Core Competencies:

At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high quality care. (Interpersonal and Communication Skills, Professionalism)

- Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)
- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions in both the outpatient and inpatient settings. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood. (Interpersonal and Communications Skills)
- Recognize his or her own practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

B. Service Goals:

The family practitioner must be competent to manage the care of his/her patients in the hospital, either in its entirety or as the coordinator and manager of the more complex patients involving multiple specialists. In addition, the practitioner cares for the patient pre- and post-hospitalization and interacts with family members as appropriate. The skills and experience therefore go well beyond a disease/illness orientation. The RRC in Family Practice considers this experience so important that it requires the family practice resident to follow any of their continuity patients when admitted to the hospital unless their current rotation makes this impossible (e.g. Away Elective). Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description:

All resident adult and pediatric continuity patients and Mercy Family Health Center (MFHC) faculty patients are admitted to the Family Practice Service (FPS).

D. Duties

All Residents are required to follow their continuity patients in-house along with the FPS team, writing a "primary care doctor" note daily. While this can be a challenge at times, continuity of care is a foundation of family practice and one of the Essential Requirements of the ACGME. One PGY III resident is assigned to the service each rotation and provides primary in-house coverage for patients and meets daily with Family

Practice preceptors who rotate onto the service each week. This senior resident “runs” the service and has oversight of continuity residents as well. On weekends, holidays, and after 5:00 p.m., the residents on call (PGY1, PGY2, PGY3) will be responsible for covering the FPS patients in addition to other service patients on medicine, pediatrics and obstetrics.

Residents are expected to round on all patients between 7:00 am and 9:00 am. Rounds with the attending have been occurring from 8:00 am to 9:00 am. This is arranged on an attending-by attending basis. Outpatient clinic is an important part of this rotation. Residents will be in the FPC from 10 to 12, seeing work-ins, hospital follow-ups, acute patients, and their own continuity patients.

When a resident (or faculty member) sees and admits his/her continuity patient from MFHC, it is the responsibility of that PCP (Primary Care Physician) in the clinic to enter admit orders and the admission H&P. If another provider is seeing the patient and the FP service resident is available, the FP service resident should do admit orders and the H&P. If the FP service resident is not available, then admit orders and the H&P are to be done by the provider seeing the patient at clinic. It is the duty of the physician writing the admission orders to contact the FPS preceptor at the time of admission.

The PCP of admitted patients, whether resident or faculty, should be alerted that their patient is in house no later than the morning following admission on weekdays, and on Monday morning for weekend admissions. PCPs are expected to round daily on weekdays, and to be actively involved in their patient’s care and disposition on discharge. MFHC continuity OB patients are to be taken care of by their PCP or their OB resident partners under the supervisions of OB faculty or on call FP Faculty who supervise on labor and deliver (Dr. Solkovits & Dr. Moranda). Newborns go to the FP Service. Once six patients are on the FP service, a redistribution policy can go into effect unless the FP service team (resident & attending) agrees not to enact the policy. Once the policy is enacted, faculty and/or 3rd year resident patients that have been on the service the longest will be taken over by their PCP until six or fewer patients are on the service (the family practice attending physician will continue to provide preceptor services to the PGY3 in such circumstances). If the service still has an excess number of patients, PGY2s will assume care of their continuity patients with attending backup. All patients being taken care of by their PCPs will remain on the FPS computer list. Once a patient's care is taken over by his PCP, that person will provide care throughout the remainder of the hospital stay. Well newborns will not count towards the total number of patients on the service and should be followed by the resident providing care for the newly delivered mom. The faculty members or senior residents following their own patients are responsible to sign out those patients before 5:30pm Mon. - Fri to the FPS resident so the resident can provide night sign-on for the call team. During evening and weekend hours the on-call residents will provide care for both FPS patients and those patients whose hospital care has been assumed by their PCP. The FP service will never close to FP ER admissions.

Faculty Notification Guidelines: The FPS preceptor **MUST** be notified at the time of admission for all emergency room and direct admits after the patient has been

evaluated by the admitting resident (or faculty member). Admissions or transfers to any of the critical care units **MUST** involve the immediate notification of the preceptor who is required to personally see the patient within four hours. The preceptor should be notified of any significant deterioration in the status of any service patient. The preceptor should also be notified of all sick or unstable newborns at the time of birth or deterioration. For normal, stable, uncomplicated healthy newborns, the preceptor can be notified in the morning following birth. Note: it is the responsibility of the resident or faculty member arranging the direct admission of a patient from the FPC to directly contact the on-call FPS preceptor to relay the appropriate information regarding the admission. Timely contact allows the attending to make appropriate arrangements to see the patient and assist with care without delay. The FPS resident will be admitting ER admissions by phone when scheduled in the FPC, and must inform the preceptor at the time of admission.

Expectations and Duties: The FPS intends to have the senior resident function as a “real world” family physician, combining inpatient duties with ongoing office responsibilities. We encourage, and expect, the senior resident will function with greater autonomy than when on categorical services. The preceptor, who remains ultimately the attending physician of record, should serve more as a consultant and role model to the senior resident while at the same time exercising his/her supervisory responsibilities.

The preceptor should be available from 8:00am to 10:00 am on weekdays for rounds; earlier rounding times, or afternoon rounding times maybe negotiated under unusual circumstances only. This timing is critical, as the resident is expected in clinic for scheduled patients at 10:00 am. Sit-down-rounds, followed by bedside rounds of new and critical patients, will have to be accomplished efficiently. The attending will then have another hour to complete notes and contact the resident by phone with any important communications. The attending will still be responsible to supervise care of patients handed over to their PCP by the Cap. The preceptor is responsible for ensuring the PCP residents round on their patients.

Change of service for attendings occurs Friday at noon. Weekend and holiday rounding times should start no later than 9:00 am. As the covering resident team on weekends frequently does not include the FPS resident, close communication between attend and the on-call team is essential.

GYNECOLOGY (PGY2, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to sensitive issues, and collaborative

- care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling, based on the patient's age and risk factors. (Patient Care, Medical Knowledge)
 - Be able to perform routine gynecological procedures (Patient Care, Medical Knowledge)
 - Develop treatment plans for common conditions affecting female patients, including reproductive issues, utilizing community resources when indicated. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
 - Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women. (Patient Care, Interpersonal and Communication Skills)
 - Consult with obstetrician-gynecologists, other physician specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
 - Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice)

B. Service Goals

As a second and third year rotation, the gynecology experience is intended to strengthen resident's knowledge base and skills in the wide range of primary care gynecology complaints seen by a family doctor. Residents are expected to achieve the full set of defined Gynecology Competencies during this rotation. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

The various experiences in gynecology occur at SCHC, MFHC, and private offices and are described in the Clinic II Rotation. See above.

INTENSIVE CARE UNIT (PGY1, PGY2, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence

based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)

- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)

B. Service Goals

The Intensive Care Rotation in the first year is intended to immerse the resident in the critical care setting to understand guidelines for appropriate admission, manage critically ill patients, and obtain procedural experience under supervision. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description:

Each first year resident spends two weeks in the ICU and will work with one preceptor for one week at a time. Residents will round on all assigned patients, write appropriate notes, and participate in procedures. Residents also gain ICU experience while rotating on the internal medicine service.

D. Duties

Work up all assigned patients, review with the intensivists, and write daily notes in the chart. Conduct daily rounds and see patients as needed. Report all significant changes in condition to the attending.

.Attend ICU Rounds at 10 a.m.

Complete all required readings and be prepared to present/discuss with the intensivist during the tutorials.

Work with respiratory care practitioners and nurses in providing daily patient care.

Residents should keep a log in New Innovations of ICU patients cared for and their diagnoses as well as procedures performed.

INTERNAL MEDICINE SERVICE (PGY1, PGY2, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision- making capacity may refuse recommended medical treatment. (Professionalism)

B. Service Goals

The service provides resident physicians with experiences in general medicine, primarily managing common medical problems. Additionally, residents will learn to recognize uncommon problems, obtain consultations as needed or make referrals to facilities for treatment not locally available. Residents are expected to develop the full set of defined Medicine Competencies over the course of their three years' experiences. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

This service is staffed by 3 residents. The internal medicine preceptors cover for 7 days at a time. At times medical students and FNP/PA students also participate on the service. The medicine chief resident is charged with coordinating admissions and assigning patients as well as providing research on topics relevant to patient care. The service will be assigned every-other unassigned admission from the ED, although the preceptor may determine that the service is "closed" (i.e., accepting no more patients) depending on the circumstances of number of residents and patients. When admitting a patient to the service, the ED should page the primary medicine resident, (via the medicine pager). Residents are responsible for ward work, including daily notes and close monitoring of patients.

Residents will pre-round on their patients each morning. During teaching rounds (usually starting at 8:30am in the Lower Level Conference Room) the preceptor will carefully review new patients or those with acute problems and review existing patients as well. The senior will then be responsible for overseeing and assisting daytime work, consulting with the preceptor as needed. Preceptors will provide the ultimate supervision of patient care.

Between 5 p.m. and 8 a.m., and on weekends, the preceptor will be consulted promptly about any admission, with discussion of the assessment and plan. [Medicine service consultation requests by other specialists will be directly handled by the senior resident on service with approval of the attending physician. The senior resident will promptly see the patient, and provide a consultation note and dictation including the elements of a pertinent history and physical. The medicine service will then follow the patient as usual until discharge or the attending decides that signing off is appropriate.](#)

Please be sure to document preceptor involvement in patient charts. Dictate the preceptor's name on admission H&Ps, discharge summaries, and procedure notes. Discharge orders must include the current attending and the physician or clinic assuming responsibility for the patient's care after discharge. Please also send a copy of the discharge summary to the outpatient physician. Any significant communication with the attending re: the patient's status or management must be noted in the chart; especially if/when the patient's condition changes significantly. Any transfer to the ICU must be communicated immediately to the attending.

Medicine Admissions and the cap: Unassigned medicine admissions from the ED are alternated with the hospitalist's service. This should even out the flow of admissions and allow for an appropriate service census. The attending of the week has the authority to determine the service "full" and invoke the cap. The medicine cap works as follows:

- The number and acuity of patients and the number of residents on service will determine total cap. Generally speaking, for four residents, the cap is 16 points, for three residents, 12 points and for two residents 8-10 points.
- Each floor patient is generally one point. An active ICU patient is two points.
- The maximum points admitted in one day = 6.
- Once the service is closed, it opens only when the day's discharges bring the service volume/acuity back under the cap.
- The medicine senior resident will let the ED know if the service is "open" or "closed."
- During the evening, the night shift resident will be responsible for contacting the ED.
- When the service is closed, all further admits will go to the ED unassigned call list.
- Each individual attending has the prerogative to go above and below the cap given the overall volume and acuity of the service.
- For PGY1s, the minimum average census should be 5 patients

D. Duties

Senior resident duties:

- See new admits each morning before rounds
- Perform all consults at the attending's direction.
- Assure that ICU patients are seen twice a day
- Pre-round each day with the PGY1s if appropriate
- Review progress notes each day
- Write backup admit notes on all admits and review all orders when on duty in the hospital
- Assign admissions
- Spend what time is available and appropriate to support the teaching functions of the service
- Encourage team efforts and support
- Give feedback and evaluations to junior residents
- Provide appropriate sign out of the Medicine Service to covering resident when going to afternoon continuity clinic. To facilitate this, the senior resident will have his/her afternoon continuity clinic blocked off for the first time slot and the resident will not be expected at clinic until 2:00 pm. (Note: Only the senior resident on IMS will have clinic schedule blocked for this purpose).

A

Junior resident duties:

- Admit patients from the ED and other sources as assigned by the senior resident
- Follow those patients each day with assistance as needed from the senior resident and attending.
- Update computer sign out notes daily
- Call for any needed specialty consults
- Follow-up on all lab and imaging tests ordered, and on information provided by consultants

Resident Duties on Weekends and Holidays - coverage of patients on the service

First call:

- The first call residents on each service who are coming on and going off will divide up the patients on the service, see them with the assistance of the second call resident and attending, and write daily progress notes.
- First call residents are responsible for dictating an H&P at the time of every new admission.

Second call (if applicable):

- The second call resident will see all new admits and review orders and notes. He will also be responsible for assigning admissions to the service.

Third call (if applicable)

- The third call resident will be available for assistance/supervision as needed. (Also see Call Policy)

* Weekday sign out to the resident on call will be between 5-5:30 p.m.

Clinical duties for residents working at Mercy Family Health Center must be completed prior to attending sign out.

* Any changes to the call schedule should be made at least two weeks in advance.

* The senior resident will contact the oncoming preceptor about rounding and communicate this information to the rest of the team at least one day in advance.

Short Call (if applicable)

- From 7 am until 10 am on weekends, this resident assists with inpatient rounds.

Attending duties:

- Be the attending physician of record and supervise care according to the Graduate Medical Education Committee policy.
- Round daily with residents, review service notes, see the patients on service and make personal chart documentation as appropriate.
- Be available to residents for specific questions related to the management of patients on the service.
- Supervise residents as appropriate for any procedures.

- Complete an evaluation on each resident's performance and review the evaluation in person with the resident. (Please see EVALUATION, SECTION)

A full-time faculty member, Dr. Nena Perry, is the coordinating attending. She is responsible for overseeing the residents' overall responsibilities and experience and providing assistance with issues as they arise.

Physician Guidelines for Admit Status

The decision for admission status to the hospital is a complex medical decision based on the provider's judgment and the patient's need for medically necessary care.

The patient placement order must be completed or co-signed by a provider with admitting privileges at Mercy Redding

Inpatient: A term used to describe a person admitted to a hospital for at least 24 hours. The necessity for admission must meet both severity of illness and intensity of service by Interqual criteria.

The following documentation is required for the admission of a patient to Inpatient status:

1. The order and location for patient placement
2. Reason for hospitalization
3. The need for care requiring greater than 24 hours (2+ midnight for Medicare)
4. Evidence of services planned or provided
5. The discharge plan for the patient

Observation: Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged within 24 to 48 hours. Observation is the status to use for the patient who will require \leq 24 hours of care before being able to be discharged.

Outpatient: Defined by CMS using surgical or procedural CPT codes. This patient is being brought into the hospital for ambulatory services like surgery, lab, radiology, endoscopy or OB checks that typically do not require an overnight stay.

Outpatient in a Bed: A new term for patients who have had an outpatient surgery/procedure but require an overnight stay for supervision. The patient does not have an adverse condition but would benefit from staying overnight rather than going home. The expectation is that this patient will go home immediately in the am.

** These are basic guidelines. If you need assistance with patient placement issues please feel free to call the ED case manager at ext. 6413.

Consultation Etiquette

When consulting an intensivist or other specialist, please follow these three steps:

- 1. State the problem or the presumed diagnosis and then offer key details that support the reason for the call.**
- 2. Formulate as best as you can a differential diagnosis AND what you think the next steps should be to address the problem, AFTER having evaluated the patient and researching solutions.**
- 3. Be available to meet the specialist at the patient's bedside. If the patient is critically ill, this should be a top priority.**

INTERNAL MEDICINE-NIGHT SHIFT (PGY1, PGY2, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Be able to perform standardized comprehensive critical care assessments and develop acute treatment plans. (Patient Care, Medical Knowledge)
- Be able to optimize treatment plans using a systematic approach to medical decision making and patient care, combining scientific evidence and clinical judgment with patient values and preferences. Knowledge should be evidence based and from nationally recognized resources. (Systems-based Practice, Practice-based Learning and Improvement)
- Coordinate admissions, inpatient care, and throughput within the hospital system. (Systems-based Practice)
- Demonstrate the ability to communicate in multiple modalities with patients, families, other health care providers, and administrators. Effective communication is central to the role of the family physician to promote efficient, safe, and high quality care. (Interpersonal and Communication Skills, Professionalism)
- Recognize self-limitations with regards to practice and seek consultation with other health care providers to provide optimal care. Assess medical information to support self-directed learning (Medical Knowledge, Practice-based learning and improvement)
- Demonstrate compassion, empathy, and sensitivity towards hospitalized patients and appreciate that informed adults with decision-making capacity may refuse recommended medical treatment. (Professionalism)

A. Service Goals

The purpose of this rotation is to maintain the internal medicine educational goals while decreasing the amount of call and fatigue associated with traditional call. The night shift rotation helps us maintain our educational and service objectives while adhering to the ACGME work hour restrictions. The educational goals of the night shift rotations are similar to those described on the internal medicine service. The service provides resident physicians with experiences in

general medicine, primarily managing common medical problems. In addition, residents will learn to recognize uncommon problems and obtain consultations when needed. Residents are expected to develop the full set of defined Medicine Competencies over the course of their three years' experiences. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

The service is staffed by a single resident working closely with the internal medicine service and internal medicine service attending. Residents are expected to do a minimum of 2 weeks of night float in each academic year. PGY1s will always have an upper level resident available on the Night float Ob/Pediatrics service to provide supervision. The night shift resident will work from 5:30 p.m. to the 7 a.m. check out. The night shift resident will work five shifts Monday-Friday. In addition, the night shift resident has family practice clinic on Monday afternoons. Admission policies are described in the internal medicine rotation section above. The night shift should review all admissions with the attending physician during the night or prior to end of shift – this assures both quality of care for the patient and education for the resident.

D. Service Duties

The night shift resident duties are as follows:

- Admit new patients from the ED
- Supervise first year residents on short –call
- Perform Consults
- Follow-up on patient care issues as requested during check-out
- Update computer sign-outs as necessary
- Assist with Saturday morning rounds if the combined number of patients on FPS/Medicine exceeds ten.

If the combined number is:

- 11-15:** the night shift resident rounds on the number of patients >10.
- >15:** the excess patients (over ten) are evenly distributed among the available residents including the night shift resident.

With the approval and supervision of emergency room attendings, night shift residents are encouraged to seek experiences in the emergency room as time allows.

OUTSIDE TELEPHONE CALLS

1. All outside telephone calls should be directed to the backup resident.
2. Accept outside calls only from these patients:
 - a. MFHC resident or faculty patients
 - b. SCHC Resident Patients

3. Advice given over the telephone should be limited and treated with considerable caution, given the absence of medical records, no prior knowledge of the patient, and inability to perform a physical exam.
4. All conversations with patients should be documented immediately and sent to the clinic providing the patient's care for review. Documentation should also include the following:
 - a. Your name, the doctor creating the note (who took the patient's call)
 - b. Patient's name (use for acct #99999999)
 - c. Patient's DOB
 - d. Date of the telephone report
 - e. Presenting problem or question
 - f. Any discussion
 - g. Impression
 - h. Instructions given to patient
5. Consider concluding all conversations and documenting in your report that you *advised the patient that ability to provide medical care over the phone is limited. Therefore, the patient must go to the Emergency Department for further evaluation of urgent conditions.* If the decision is made for the patient to see their own doctor for follow-up, have them set up the earliest possible appointment and to seek care at the Emergency Department if the problem persists, or worsens.
6. If the patient needs a refill for pain medications or other controlled substances, have them follow-up with their private physician or go to the ED. In very rare circumstances, using your judgment, you may fax to their pharmacy a refill prescription with a limited amount of medication to last until their clinic re-opens.

PEDIATRICS/OB (PGY1, PGY2, PGY3)

A. Core Competencies

Pediatrics:

At the completion of residency training, a family medicine resident should:

- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions in both the outpatient and inpatient settings. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood. (Interpersonal and Communications Skills)

- Recognize his or her own practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

Obstetrics

- Be able to communicate effectively with female patients of all ages, demonstrating active listening skills, a respectful approach to issues that may be sensitive for women, and collaborative care-planning with the patient. (Interpersonal and Communication Skills, Professionalism)
- Be able to perform comprehensive physical examinations of female anatomy with appropriate screening tests for pregnant and non-pregnant women, and be able to perform routine gynecological and obstetrical procedures (detailed below). (Patient Care, Medical Knowledge)
- Develop treatment plans for common gynecologic conditions and pregnancy complications, utilizing community resources when indicated, and demonstrate appropriate post-operative care following caesarean section or gynecologic surgery, both inpatient and for office follow-up. (Medical Knowledge, Systems-based Practice, Practice-based Learning and Improvement)
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive issues in women as well as comprehensive wellness counseling based on the patient's age and risk factors. (Patient Care and Interpersonal and Communication Skills)
- Consult and communicate appropriately with obstetrician-gynecologists, maternal fetal medicine specialists, and allied care providers to provide optimum health services for women. (Medical Knowledge, Systems-based Practice)
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care. (Systems-based Practice, Professionalism)

B. Service Goals:

The success of this service will require the senior resident to carefully manage the demands of the various services against his/her resources, assign duties, adjust for volume and acuity, have the full support of the attendings and the understanding of the nurses. Open communication will be critical. On-time Rounds must be maintained to get through the teaching and supervision tasks of the morning. Finally, there will be times when the residents will not be able to cover all patients and attendings on OB may be required to deliver patients; this option should be uncommon.

The **OB** component provides intensive obstetrical training, giving residents a broad knowledge and experiential base in normal and abnormal obstetrics. Residents will learn to diagnose and manage common OB problems, obtain consultations as needed and make

referrals when appropriate to facilities that can provide services not available locally. Residents are expected to achieve the full set of defined Obstetrics Competencies over the course of their three years' experiences.

The **pediatric** in-patient component provides intensive pediatric training throughout the 3 years of residency training. Residents will diagnose and manage common pediatric problems and will learn to recognize uncommon problems, to obtain pediatric and neonatology consultations and to make referrals to facilities, which can provide services not available at Mercy Medical Center. Residents are expected to develop the full set of defined Pediatric Competencies over the course of their three years' experiences.

Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description:

Obstetrics

The residents will, actively participate in all deliveries involving patients from Mercy Maternity Clinic. The patient population consists of a spectrum of patients from the uncomplicated to the very complex. The experience continues throughout all three years on rotations and during the on-call periods. Preceptors are ultimately responsible for the care delivered by the residents in the clinic and hospital, and are assigned for 24-hour shifts to supervise these areas in compliance with the Mercy Medical Center Policy on Resident Supervision. They are expected to be physically present at all deliveries, and to supervise Mercy Maternity Center for standard procedures. Teaching rounds at the hospital should address all current L&D, postpartum and GYN patients as well as provide time to plan the coming day's events. **NOTE: Obstetric patients involved in Trauma, seen in our ED, and admitted, must be discussed between the ED attending and the OB attending prior to admission per MMCR Policy.**

Residents should meet in the OB nurses station as arranged with the OB attending and be prepared to present all OB/GYN patients to the OB attending. Coordination with the attending is especially important prior to the weekend so that rounds occur smoothly and the resident familiar with the service patients can be available to round with the attending. As time and hospital duties allow, residents may spend a limited amount of time providing prenatal and postpartum care for the **Mercy Maternity Clinic** patients at the outpatient clinic

Pediatrics

In the **Nursery**, the residents are responsible for doing admission History & Physicals on all of the babies admitted to their service, regardless of the time of day in which they were delivered. On the weekends, it will be the responsibility of the covering resident to perform this duty. (For more information about newborn care for MFHC patients, see heading IV. MERCY FAMILY HEALTH CENTER: section II. CLINICAL AREAS:

NEWBORN CARE.) Residents are responsible for patients > 36 weeks in the normal newborn nursery. Involvement in intensive care patients is encouraged, especially to become proficient in resuscitation and procedures for stabilization. After the patient is stabilized, the resident may withdraw from the case with the agreement of the preceptor. With all newborns, including "normal cases" it is expected that the resident will write appropriate daily notes. A brief delivery note must accompany the newborn to the nursery. This should include:

- Type of delivery, with or without complications,
- Condition of amniotic fluid,
- Apgars, resuscitation,
- Evidence of fetal distress,
- Visualization of cords,
- Complications, etc.

On the **Pediatric Ward**, the resident will follow all service patients. Pediatric ICU patients will be managed by the intensivist or pediatric attending, often in conjunction with Pediatric Intensivists at UC Davis via Telemedicine Consultation. Residents will round with the intensivist on the patients they admit to the ICU and be prepared to re-assume care when the patient leaves the ICU setting.

The residents care for service patients in the pediatric ward and in the newborn nursery. Residents should meet as arranged with the pediatric and newborn nursery attendings and be prepared to present patients to the pediatric attendings according to their preferred schedules. Coordination with the attendings is especially important prior to the weekend so that rounds occur smoothly and the resident familiar with the service patients can be available to round with the attending.

Night Float Ob/Peds

The service is staffed by a single resident working closely with the obstetrical service and pediatric service attendings. Residents are expected to do a minimum of 2 weeks of night float Ob/Peds in each academic year. PGY1s will always have an upper level resident available on the Night float Medicine service to provide supervision. The night shift resident will work from 5:30 p.m. to the 7 a.m. check out. The night shift resident will work five shifts Monday-Friday. In addition, the night shift resident has family practice clinic on Monday afternoons. Admission policies are described in the Ob and Peds rotation section above. The night shift should review all admissions with the attending physician during the night or prior to end of shift – this assures both quality of care for the patient and education for the resident.

D. Service Duties:

Overview: The resident team (excluding the night float resident) will generally consist of one PGY1 and one senior residents. Each senior resident/ PGY1 team generally

spends two 2-week blocks alternating between the pediatric and obstetrical service. The senior resident is the team leader and assigns duties as appropriate. Each attending for OB, Pediatric, and NICU will arrange with the senior resident the time for rounding. See also Night Float Ob/Peds above.

MFHC Clinic:

- Residents scheduled in the FPC must arrive at the FPC on time for their first appointment. These patients count on you being there.
- The PGY2 or PGY3 resident in house will manage the POB service, assign PGY1s to admissions, L&D, etc.

Admits:

- Newborns from attendings who do not do Nursery care will be managed on the newborn service with the senior assigning those newborns to first year residents as appropriate.
- Pediatric ward admissions will be followed by the team member who performed the admission, or assigned if the admission occurred during the on-call period.

Mercy OB Clinic:

- As available, PGY1 or PGY2 residents will attend the Mercy OB clinic Tuesday morning, Wednesday afternoon, and Thursday morning as scheduled by the senior resident and ONLY if there is an on-site supervising attending in order to comply with Medicare and MediCal supervision guidelines, ensure procedural supervision and attainment of competency, and ensure the appropriate care of the often complicated prenatal patients seen in the MOB clinic.

Checkout:

- Service Checkout in L&D will occur when all residents are available

E. Service Guidelines: OBSTETRICS SERVICE

Residents are responsible for:

- Managing prenatal care at the Mercy Maternity based on the schedule defined above.
- Managing labor and delivery and postpartum care of patients from the Mercy Maternity Clinic or unassigned patients.
- Notifying the attending preceptor of patients being admitted in labor and all discharges. Residents shall also contact the attending preceptor about management plans including when to call the attending with updates on labor and for the delivery. Residents must present cases in a standard format and interns should discuss with upper level residents before calling the attending after hours and on weekends:
 - Gravida _ Para _ AB _
 - Age
 - EDC

- Presenting condition
 - Onset of labor
 - Contraction pattern and intensity
 - Membranes
 - Dilatation
 - Station
 - Vitals
 - Strips or other tests
 - Complications if any
- Prenatal course
- Plan
- All deliveries will be done with preceptor in attendance. It is the resident's responsibility to communicate appropriately with attendings on the progress of labor and the expected time (as much as this is possible!) of delivery.
- The delivery note on the mother's chart should comply with Mercy Medical Center operative note guidelines.
- The OB residents are expected to pre-round and be prepared for daily inpatient obstetrics rounds with the attending of the day by having seen each patient and formulated a management plan prior to the attending's arrival at 8 am.
- All L&D patients cared for by the residency program service must be evaluated in person and discussed with the attending. This includes patients who are sent home without being admitted (rule out labor, etc.) A note should then be placed in the chart documenting this care.
- In the Maternity Clinic, residents will provide patient care along with the nurse practitioners under the supervision of the OB attending.
- When the need to perform an emergency C-Section arises, the following procedure should be pursued:
 - Call the OB attending regarding the case.
 - If the OB attending agrees C-section is needed, notify the OB nursing staff and make sure they contact the anesthesiologist.
 - Dictate an H&P for the patient before the C-section unless it is a "crash" C-section.
 - Contact the on call neonatologist as discussed with the obstetrician.
- Residents are expected to attend Noon Conferences unless an urgent patient responsibility takes precedence (e.g. a delivery. Seeing routine prenatal patients at Mercy Maternity Center is not a reason to miss noon conference).
- Compliance with these guidelines is essential to a determination of "successful completion" of this rotation.

F. Service Guidelines: PEDIATRICS IN-PATIENT SERVICE

1. Inpatient Service

- a. Complete history and physical examination, appropriate orders and procedures
- b. Learn appropriate diagnosis, treatment and management of common pediatric hospital problems.

- c. Write appropriate progress notes, communicate with parents, referring doctors and involved agencies
 - d. Dictate discharge summaries
 - e. Arrange appropriate follow up plan for outpatient visit(s)
 - f. Maintain appropriate partnership relationships with fellow residents
2. Newborn Nursery
- a. Follow sick or high-risk neonates > 36 weeks with attending neonatologist
 - b. Attend high risk deliveries with neonatal nurse/ neonatologist
 - c. Attend C-sections on request
 - d. Make appropriate follow-up referral to pediatric clinic
 - e. Collaborate on Family Practice newborns with resident if needed.
 - f. Gain experience at neonatal circumcision if done as in-patient.

G. Monthly Perinatal Morbidity and Mortality Conference:

M&M Guidelines:

- M&M's will be scheduled each year on the fourth Monday of the month (see below).
- Cases will be coordinated and scheduled by Dr. Clint Evans. The obstetrical and neonatal attendings will assist in identifying appropriate cases for review.
- The PGY1 who was on OB service the month prior will be assigned to present the case. Most residents will present twice during their residency training. They may need to present during their second or third year of training.
 -
- PowerPoint presentations and overheads should be used that clarify the patient's course, including key events, rhythm strips, x-rays, etc. These will substantially improve the effectiveness and professionalism of the presentation and are expected.
- There may be "last minute" cases worth presenting where thorough preparation is not possible but where the value of the discussion makes it worth the exception. This could also include an OB case at a Neonatology M&M, or vice versa.
- Patient confidentiality should be maintained.
- Outline for Perinatal M&M presentations:
 - Residents will choose an OB case of interest for the purpose of discussing proper management.
 - Although most cases will involve the resident they can also include cases in which the resident was not involved.
 - Typically, the case chosen will involve a discussion of ways to achieve best possible outcomes and available guidelines.
 - The presentation will involve a case overview which will include the basic facts of the case.
 - Residents are asked to pay particular attention to researching the details to avoid unnecessary time spent debating details with the audience.

- The case overview will involve the initial presentation, hospital course, and outcome.
- If possible the presentation will include copies of the fetal heart tracing, toco monitor, and imaging. If not available, similar strips and imaging may be available on the Internet to demonstrate examples of the condition being presented.
- This will be followed by a discussion which will include a definition of the condition, current recommended screening and management.
- Residents may email a copy of their PowerPoint to Dr. Evans for review and to receive advice prior to their M&M presentation.

OPHTHALMOLOGY (PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Demonstrate an understanding of the impact of ocular illness and dysfunction on patients and their families. (Patient Care, Professionalism)
- Demonstrate an understanding of the ophthalmic consultant's role, including the different responsibilities of ophthalmologists, optometrists and opticians. (Professionalism, Systems-based Practice)
- Recognize his or her own practice limitations and seek consultation with other health care providers when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

B. Service Goals

The goal of this rotation is to prepare a resident to enter practice with the knowledge, attitudes and skills to effectively perform an ophthalmologic evaluation, initiate management and seek consultation on patients with more complex ophthalmologic conditions. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

The ophthalmology rotation is integrated into a 6 week block in the third year of residency along with Urology, Cardiology, and ENT and is designed to expose residents to the evaluation and management of common ophthalmologic conditions that present in

the ambulatory setting. The experience is based in an ophthalmologist's office practice with case based, one on one teaching. Where appropriate to accomplish educational goals, residents may accompany ophthalmology preceptors into the hospital setting to consult on hospitalized patients with ophthalmologic conditions. This rotation represents one component of a resident's training in ophthalmology. Substantial training in the primary care of patients with ophthalmologic conditions is received in the Family Practice Center. Responsibility for the medical management of inpatients with ophthalmologic complaints occurs throughout residency training.

D. Duties

Attendance at the ophthalmologist's office is scheduled. During this time you will work one on one with an ophthalmologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/week.

ORIENTATION

The goal of orientation is to prepare incoming residents for the administrative and patient care requirements for being a family resident at Mercy Medical Center. The following topics, didactics, and courses are covered during the 2017 orientation.

Mercy New Intern Orientation 2017					
	Date	time	Topic	Speaker	Location
Monday	6/19/2017	7am-8am	Resident Welcome	D. Bland, MD/D. McMullin, MD	MMC Aud AB
		8am-4pm	Mercy New Employee Orientation	Mercy Leadership	MMC Aud AB
Tuesday	6/20/2017	7:30-8am	Intern Photos	Steve Namihias, MD	MFHC Classroom
		8-9am	MMC Residency Office Orientation	S.Brewen/A. Studer	MFHC Classroom
		9am-11am	MFHC Clinic Orientation	Sharon Babcock, RN	MFHC Classroom
		11-12:15pm	Resident Handbook Review	Duane Bland, MD	MFHC Classroom
		12:30-1:30pm	Lecture		Aud CD
		1:30-2:30pm	Hospital Tour	Alan Luo, MD	
Wednesday	6/21/2017	8am-6pm	ACLS	CEEMED	MMC E-Learning Room Clairmont
Thursday	6/22/2017	8am-6pm	PALS	CEEMED	MMC E-Learning Room Clairmont
Friday	6/23/2017	7am-12pm	NRP/BLS	CEEMED	Education Classroom
		12:15pm-1:45pm	New Intern/Graduation Event	<i>SCHC- Upper Level Conference Rooms</i>	
		2-3pm	Pharmacy Orientation	Kathleen Delikowski	MMC Pharmacy
		3-5pm	Chief Orientation	Taylor-Hui/Mooneyham/Rezai	MFHC Classroom
Saturday	6/24/2017	6pm	<i>Resident Graduation Ceremony</i>		<i>Riverview Country Club</i>
Sunday	6/25/2017				

Monday	6/26/2017	8-9am	Home Health and Hospice Orientation	Lyn Davis & Claudia Cruz-Garner	MFHC Classroom
		9-9:30am	Social Services Care Coordination	Dr. Stone/Diane Livingston	MFHC Classroom
		10-11am	Compassion in Medicine	Debbie Lupeika, MD	MFHC Classroom
		12:30-1:30pm	CLIA TESTING	Steve Namihias, MD	Aud CD
		1:45-2:15pm	PACS Training	Tina Trabold	Mercy Radiology
		2:30-3pm	Library Tour	Debbie Monroe	Mercy Library
Tuesday	6/27/2017	8-9am	My Journey	Stacy Brewen	MFHC Classroom
		9-10am	Maternal Child Services	Belinda Jaramillo	MFHC Classroom
		10-11am	OB Continuity	Clint Evans, DO	MFHC Classroom
		11:15-12:15pm	OB Clinic Orientation	Joyce Heldreth, RN	MMC OB Clinic
		12:30-1:30pm	lecture		Aud CD
		1:30-2:30pm			MMC
		2:45-4:45pm	Skills Assessment	Clint Evans,DO/Jay Roitman, DO	MFHC Classroom
Wednesday	6/28/2017	8am-10:30am	Minor Surgery Training	Drs. Namihias and Roitman	MFHC Classroom
		10:30-12:15pm	Perineal Repair	M. Leininger/D. Lupeika/P. Davainis	MFHC Classroom
		12:30-1:30pm	Perinatal M&M		Kennett Diamond Conf Room
		1:45-2:15pm	Pediatric and Newborn Nursery	C. Traugott/P. Davainis	Peds or LLCR
		2:15-2:30pm	OB Floor Tour	P. Davainis/A. Mooneyham	OB Floor
		2:30-3:00pm	OB Sterile Technique	Davainis/OB Scrub Tech(Wendy Calvert)	OB Floor/OB OR
		3:00-3:45pm	Mock Delivery	P. Davainis/Carey Walker/Kendra Schube	Labor & Delivery
		3:45-4:15pm	Perinatal Safety Core Measures	T. Gibb	Newborn Nursery
Thursday	6/29/2017	8-4:30pm	Mercy Residents-Inpt/Outpt Cerner Trng	Cherie Williams	MMC E-Learning Room Clairmont
Friday	6/30/2017	7-12:30pm	Inpatient Rounds Shadowing		
		12:30-1:30pm	Grand Rounds-Concussions	Erin Livingston, MD	Aud ABCD
		1:45pm-3:45pm	Orientation Wrap-Up	Duane Bland, MD/D. Lupeika, MD	MFHC Classroom
		3:45-5pm	Chief Resident Orientation Wrap Up	Taylor-Hui/Mooneyham/Rezai	MFHC Classroom

ORTHOPEDICS / SPORTS MEDICINE (PGY1, PGY2, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Perform an appropriate musculoskeletal history and physical examination, and formulate an appropriate differential diagnosis and recommend treatment, including requisite subspecialty referrals (Patient Care, Medical Knowledge, Systems-based Practice)
- Perform an evidence-based, age-appropriate, and activity-specific pre-participation physical examination (Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism)
- Communicate effectively with a wide range of individuals regarding musculoskeletal health care, including patients, their families, coaches, school administrators, and employers (Interpersonal and Communication Skills)

- Understand how exercise impacts disease states such as diabetes and hypertension and be able to formulate an appropriate exercise prescription (Patient Care, Medical Knowledge, Interpersonal and Communication Skills)
- Understand that sports medicine involves caring for the medical conditions of athletes in addition to the musculoskeletal conditions (Patient Care

C. Service Goals:

Musculoskeletal injuries comprise a common part of family medicine, and family physicians provide a huge amount of school and team medicine in the communities we serve. Degenerative arthritis is becoming a constantly growing problem as our population ages and as our youth's obesity epidemic grows. This rotation is intended to prepare the resident to appropriately manage such problems. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com .

C. Service Description:

Residents are assigned to various orthopedic physicians, sports medicine fellowship trained physicians (both family medicine and orthopedic), physical therapists, physiatrists, and trainers in this rotation. Residents will attend at least one major athletic event and will assist in pre-participation evaluations which, given the nature of the sports seasons, may not happen during this actual rotation. Residents spend a total of 8 weeks on musculoskeletal medicine rotations. In addition orthopedics specialty clinics occur while on the Clinic 1 rotation up to two times per month. The sports medicine component of this rotation involves the following: 1) Working the with sports medicine fellowship trained family physician, Dr. Tony Chang, in his office, at athletic events and post-game clinics and 2) Participating in pre-participation physical exams at local schools. In addition, residents work with Dr. Schillen, who is a sports medicine fellowship trained orthopedic surgeon who combines sports medicine and general orthopedics in his practice.

Didactic training will include the following lecture topics covered during the course of residency training:

- 1) Shoulder anatomy and exam
- 2) spine anatomy and exam
- 3) Knee anatomy and exam
- 4) Hip anatomy and exam
- 5) Ankle/foot anatomy and exam
- 6) Elbow/wrist anatomy and exam
- 7) Hand anatomy and exam
- 8) Fracture care/splinting/casting
- 9) Sports nutrition/supplements

- 10) Concussion
- 11) Athlete's heart
- 12) Pre-participatory Sports Physical Exam

D. Duties:

During the orthopedic/sports medicine rotation, resident are assigned to work with a variety health care providers covering a broad spectrum of musculoskeletal medicine – orthopedic surgery, casting, sports medicine, physiatry, athletic training, and physical therapy, A schedule of sporting events is produced by the residency office for the block rotations. In addition, residents must participate in a pre-participation evaluation event at least two times over three years (total = 2) and attend at least one athletic event with a physician. Some sporting events as well as minimum of two pre-participation -physicals take place in the evenings and Saturdays, and will count toward rotational requirements/hours.

PEDIATRIC OUTPATIENT ROTATION (PGY2)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Demonstrate the ability to take an age-appropriate history and perform a physical exam. (Patient Care, Medical Knowledge)
- Synthesize an appropriate diagnosis and treatment plan for common pediatric conditions in both the outpatient and inpatient settings. (Patient Care, Medical Knowledge)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and the treatment plan are clearly understood. (Interpersonal and Communications Skills)
- Recognize his or her own practice limitations and seek consultation with other health care providers and resources when necessary to provide optimal patient care. (Professionalism, Systems-based Practice)

B. Service Goals

The goal of this rotation is to expose first year residents to common ambulatory pediatric problems. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com .

C. Service Description

First year residents will spend 4 weeks on this service working with an attending pediatrician at Shasta Community Health Center.

D. Duties

Residents will work at the SCHC pediatric clinic Monday through Friday. Residents will continue to have continuity clinic at MFHC during this rotation.

MANAGEMENT OF HEALTH SYSTEMS (PGY1, PGY2, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Demonstrate physician leadership as an uncompromising advocate for patient-centered care of the highest value within the constraints of a viable and sustainable business model for the Patient-Centered Medical Home (PCMH), Patient-Centered Medical Neighborhood (PCMN), and the Health Home (Healthy Community) for the patient's welfare while balancing the business realities of practice management and financial success. (Patient Care and Professionalism)
- Actively conduct a practice search, interviews, contract negotiations, and successfully enter practice. (Interpersonal and Communication Skills)
- Demonstrate knowledge of the legalities and ethics of hiring, promoting, and firing of employees in a practice setting. (Professionalism)
- Identify the structure and operations of health organizations and systems, and the role of the family physician in this structure. (Systems-based Practice)
- Identify the measures of health, including determinants of health, health indicators, and health disparities. Advocate for the development of value metrics which will optimize Meaningful Use reporting and payment for value in the healthcare system. (Practice Based Learning and Improvement)
- Identify and foster partnerships that maximize achievement of public health goals. (Systems-based Practice)

B. Service Goals

This instruction is integrated throughout the three years of training to develop management and leadership skills in the resident including both the didactic and the practical settings. The curriculum prepares residents to assume leadership roles in their practices, their communities, and the profession of medicine. Mercy Family Health Center (MFHC) is considered the primary site for teaching management and leadership skills, and serves as an example on which residents may model their future practices. Residents also work with community and rural physicians to further develop their practice management skills. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

The curriculum for Management of Health Systems involves a variety of formats to achieve over 100 hours of instruction in both the didactic and the practical settings. A summary of hours can be found below under item 11.

1. Intern Orientation Activities

All interns receive at least 15 hours of health systems management training during a two week orientation period.

a. Department Director Meetings

Interns meet with inpatient and outpatient department directors, learning the policies and procedures of each department. They learn how to work with and lead the ancillary staff of the hospital and clinic.

b. MyJourney@DignityHealth Training

During orientation time, interns also participate in a Dignity Health, online training which is an online compliance/education program. This training will occur during orientation and intermittently throughout residency training, covering the areas of

i. Compliance

ii. Billing

iii. Ethics, including review of fraud and abuse laws

2. Medical Staff Quality Improvement Meetings and Presentations

Residents participate in several medical staff meetings and presentations, including the monthly Perinatal Morbidity and Mortality Conference, Friday Grand Rounds, and Journal Club, and weekly Morning Report. During these presentations, residents discuss and receive feedback from the residency faculty and medical staff on case presentations and quality care improvement. Residents participate by developing and providing presentations which are evaluated by faculty physicians and medical staff physicians. Residents also evaluate presentations provided by community and faculty physicians.

3. Inpatient Resident Physician Assessment and Evaluation Training

Senior residents evaluate junior residents for all inpatient rotations, including OB, Peds, and Internal Medicine. Residents also evaluate their attending physicians regarding the quality of instruction provided.

4. Health Systems Management Training at MFHC

This training has several components through all three years of residency training as outlined below.

a. Clinic Staff Team Training and Billing Education

Interns spend two hours observing and learning the role of each member of the front office and nursing staff. This experience allows them to better know each member of the healthcare team and how they function in the clinic. They also receive instruction regarding outpatient billing.

- b. Clinic Care Coordination Training (C1 rotation)
Significant training continues during second and third years of residency when residents spend two blocks, four weeks each on the C1 Clinic Doc Rotation. On this rotation, the resident is responsible for all specialty clinics in addition to seeing their continuity patients. Residents must also review and triage daily lab results and prescription requests for all of the other residents, determining the appropriate follow-up, and making sure prescriptions are appropriately refilled for patients seen by residents on away electives or vacation.

An orientation to this rotation is provided by the Clinic Medical Director, Steve Namihas, MD. This includes a review of Clinic Doc responsibilities and ways to coordination of care with the clinic staff and specialty physicians. Dr. Namihas also performs a lab audit during this rotation to assure the quality of care provided by the C1 clinic doc and provide feedback as needed.

- c. Clinic Quality Improvement Project (ABFM rotation)
Residents will engage in a three hour quality improvement training using online tools developed by the ABFM.

5. Community Health Systems Management Training and Practice Site Evaluation

- a. Each resident will perform a thorough investigation and evaluation of at least one practice site typically during their practice management rotation (C1) using the Practice Site Evaluation instrument. While doing this, residents will learn to identify the key components of a practice and community health system. They are also encouraged to use this tool when evaluating a practice that they are considering for a future job or during their rural rotation. (More information on the Practice Management Rotation is found below. Information on job interviews can be found under the Job Interview section found under the heading Elective Rotations.)
- b. The following items are included in the Practice Site Evaluation instrument which is available in the residency office:
- Type of practice
 - Patient mix
 - Payer groups
 - Scope of practice
 - Management
 - Working conditions for physicians
 - Financial
 - Insurance
 - Patient flow
 - Personnel
 - Geographic concerns
 - Medical Records
 - Past History of Practice Changes
 - Future Plans for the Practice

- Strengths of the Practice
- Challenges
- Special Services

6. Practice Management Rotation (C1 Rotation)

- a. This rotation will include two half day training sessions for a total time of 8 hours.
- b. This will take place at private physician offices in Redding.
- c. As much as possible, this training will be scheduled towards the end of the PGY2 year and the beginning of the PGY3 year to have the greatest impact on future practice planning.
- d. If requested 12 weeks in advance, residents may schedule this rotation at other sites outside of Redding.
- e. Residents meet with the various office staff and physicians in the practice, learning how to provide patient care efficiently and effectively in a private community practice or rural health setting.
- f. Residents will learn the following skills:
 - Effective billing
 - Designing a budget and managing overhead costs
 - Collections for various insurance carriers
 - Assessing practice staffing needs
 - Understanding of office manager function
 - Personnel management and labor issues
 - Employment law and procedures
 - Integrating new technologies into one's practice
 - Determining value of patient care in one's community
 - Assessing customer satisfaction
 - Measuring clinical quality
 - Tort liability and risk management
 - Office scheduling systems
 - Use of computers in practice
 - Alternative practice models
 - Principles of public relations and media training

7. Leadership training

This will occur through a variety of means in the family health center, hospital, and community.

- a. MFHC Management Team Meetings
Resident on their C1 clinic doc rotations will serve as resident representative at least once a month during the Tuesday morning meetings with the clinic management team. Meetings include discussions of practice-related policies and procedures, business and service goals, practice efficiency, billing and staffing issues, communication with patients and co-workers, discussions of patient and provider surveys, and quality improvement.

- b. Hospital Leadership Training

Residents will also get additional leadership training while serving in one of the leadership positions or hospital committees listed below. Residents are expected to participate in at least four meetings during their residency training.

 - i. Resident Leadership (i.e. Chief Resident, UCD Conference Planning Committee)
 - ii. Hospital or Medical Staff Committees (Medical Executive Committee, Medical Division Committee, Quality Assurance Committee, Ethics Committee, Pharmacy and Therapeutics Committee, Family Practice Residency Committee, Utilization Review Committee, CME committee, etc.)

- b. Community Leadership Training

During their community medicine rotation, residents work with the county Public Health Officer learning various aspects of health in the community. They also have the opportunity to participate in a variety of public health community projects such as tobacco cessation, or STD education. Residents are encouraged to speak to community groups on health education topics.

- 8. Academic Advisor Meeting and Analysis of Clinic Productivity Reports

Residents will demonstrate progress in completion of duties and mastery of skills in the management of health systems during their bi-annual faculty advisor meetings. An academic advisor assigned for each resident will summarize the meeting using the academic counseling form. This will include the following:

 - a Review of rotation specific evaluations to assess clinical competencies
 - b Assessment of diligence in maintaining medical records
 - c Review of opportunities for future practice
 - d Completion of required documents for medical licensure
 - e Review of procedure training
 - f Analysis of FMC reports regarding individual and practice productivity and financial performance
 - g Review of patient continuity for individual resident, including number of OB patients delivered
 - h Review of Leadership Training experience

- 9. Management of Health Systems Didactic Training
 - a Management of Health Systems Lectures

Residents receive at least 4 hours of lectures each year on a variety of practice management topics, including professionalism, malpractice, evaluation of contracts, preparing for a job interview, billing and coding, and providing feedback to co-workers.
 - b MyJourney@DignityHealth

This online educational program for residents and faculty covers a number of issues including the following:

 - Leadership / Performance Improvement

- Environment of Care
- Infection Control
- Patient Rights / Ethics / Responsibilities
- Safety and Security in the Healthcare Organization
- Management of Medications
- Incident Reporting
- Redding Population Specific Care

10. Directed Reading and Study in Practice Management

Residents will spend at least four hours in directed reading of practice management materials during the C1 and 2 rotations, including:

- i. Medical Practice Management: CD and booklet available through the residency office.
- ii. AAFP training book: Quality and Patient Safety in the Physician’s Office.
- iii. AAFP Online Family Practice Management Toolbox at <http://www.aafp.org>
- iv. CAFP Practice Resource material on line at http://www.familydocs.org/practice_resources.php

11. Summary of Hours for Management of Health Systems

1. Intern Orientation Activities	15 hours
2. Medical Staff Q/I Meetings and Presentations	36 hours
3. Inpatient Resident Physician Assessment and Eval Training	6 hours
4. Health Systems Management Training at MFHC	24 hour
5. Community Health Systems Mgm and Practice Site Eval.	3 hours
6. Practice Management Rotation (C1 Rotation)	8 hours
7. Leadership Training	12 hours
8. Academic Advisor Meeting and Analysis of Clinic Reports	6 hours
9. Management of Health Systems Didactic Training	17 hours
10. <u>Directed Reading and Study in Practice Management</u>	<u>4 hours</u>
Total= 131 hours	

12. Additional Meetings

In addition to this, residents spend another 90 hours participating in a variety of additional meetings which occur regularly during residency training.

- a Bi-monthly Meetings:
 - MFHC Staff/Resident Meetings
 - Resident/Faculty Meetings

- b Monthly Meetings:
 - Director /Resident Meetings, aka “Dialogue with Duane”
 - Resident Meetings lead by the chief resident

- c Meeting Topics include the follow:
 - Health systems training

- Practice-related policies and procedures
- Business and service goals
- Budget issues
- Practice efficiency
- Patient satisfaction surveys
- Billing practices
- Staffing issues
- Ways to improve communication with patients and co-workers
- Quality improvement

D. Duties

Residents will accomplish the tasks outlined above, attend the rotations and meetings, perform the required reading, and analysis, and will maintain appropriate documentation of their training, which will be reviewed bi-annually with their academic advisor.

RADIOLOGY, LAB, ABFM ROTATION (PGY2)

The Radiology, Lab, ABFM rotation usually occurs during the second year. This rotation is a two-week block that includes continuity clinic three half-days per week. One half-day will be spent in the Clinical Laboratory, and a minimum of four half-days will be spent doing ABFM modules. The remaining time will be spent in Radiology at Mercy Medical Center. The exact number of radiology days may vary depending upon the availability of radiologists.

The following is a description of each component of this rotation.

Radiology

1. Goals and Competencies

The primary objective of the radiology portion of this rotation is to help the Family Practice resident develop the knowledge base needed to utilize radiological services for maximum patient care, safety and cost effectiveness.

At the end of residency training, a family medicine resident should:

- Be able to interpret basic radiological tests. (Patient Care)
- Understand the basic principles of radiological tests, including selection of different imaging methods and risks and benefits of various imaging modalities. (Medical Knowledge, Practice-based Learning and Improvement)
- Be knowledgeable about cost considerations of radiological testing. (Medical Knowledge, Systems-based Practice)

2. Service Description

Residents will have scheduled time during the two week rotation at Mercy Medical Center's Radiology Department.

3. Service Duties

The resident will spend pre-assigned time with radiologists who are interpreting radiological tests. In addition, residents may log in to the American College of Radiology website to go over cases online with the attending radiologist. And interventional radiologist may also ask the resident to observe procedures.

Laboratory Medicine

A. Service Goals and Competencies

The primary objective of the Lab portion of this rotation is to help the family practice resident more fully develop the knowledge base needed to effectively and efficiently manage the laboratory portion of patient care. Laboratory testing, both inpatient and outpatient, constitutes a significant portion of patients' medical care. Residents will gain an appreciation of the ordering, costs, utility and limitations of laboratory tests. Every year all residents are required to participate in CLIA lab training as well as "Provider Performed Microscopy Procedure" (PPMP) direct observation.

At the completion of residency training, a family medicine resident should:

- Be able to perform and interpret common tests done in the laboratory setting. (Patient care, Practice based-Learning and Improvement).
- Know the significance of quality control in the lab, including the importance of documentation. (Patient Care, Systems-based Practice).
- Understand the basic principles of laboratory tests, including method selection, method verification, sensitivity, specificity, precision, accuracy and bias. (Medical Knowledge, Practice-based Learning and Improvement)
- Be knowledgeable in the cost considerations of laboratory testing. (Medical Knowledge, Systems-based Practice)

B. Service Description

One 4-hour block during the Radiology, Lab, ABFM rotation occurs during the second year. This will take place in the Clinical Laboratory at Mercy Medical Center Redding

C. Service Duties

During the rotation, the resident will meet with the medical technologists in the laboratory. This will include spending time in each of the following areas: Microbiology,

Hematology, Urinalysis, Blood Bank, Chemistry, Coags, Immunology. The resident will be able to participate actively in some areas, eg. urinalysis. The medical technologist will evaluate each resident's participation and understanding. This will be reported to the lab supervisor who will then forward the assessment to the residency office.

ABFM Maintenance of Certification (MOC)

A. Service Goals and Competencies

Through this rotation, the resident will gain experience in the ABFM Maintenance of Certification process (MC-FP) which is required for achieving and maintaining family medicine board certification. (Medical knowledge)

B. Service Description

The ABFM requires completion of 50 Family Medicine Certification points in order to be eligible to sit for the ABFM Board Examination. Below are the ABFM Module requirements which must be completed prior to applying for the ABFM Exam in PGY3:

Completion of 50 Family Medicine Certification points which includes:

- Minimum of one (1) Knowledge Self-Assessment (KSA) activity (10 points each)
- Minimum of one (1) Performance Improvement (PI) activity with data from a patient population (20 points each)
- Additional approved KSA Knowledge Self-Assessment, Clinical Self-Assessment (CSA 5 points each), or Performance Improvement activities to reach a minimum of 50 points

This rotation will include four - half days to work on these modules. Residents may be scheduled additional time to complete a module during their C2 Rotation. The Performance Improvement module requires evaluation of data from our continuity patient population over a period of time and may need to be completed after the rotation. Completion of the 50 Family Medicine Certification points may involve work at home either during or outside of this rotation block.

C. Duties

The resident will access the resident portfolio to utilize the tools/modules after they have been entered into The Resident Training Management System (RTM) by the Program Coordinator. Residents will complete the modules during the scheduled rotation using a computer set up in the conference room at MFHC. You are not expected to complete all of the ABFM module requirements during these 2 weeks, but we do require the following:

Minimum Requirements for ABFM/Rad Rotation

1. Initiate PI Module
2. Complete Minimum of 1 KSA
3. Complete Minimum of 1 CSA
4. Submit evidence of module initiation and completion at the end of the rotation.

5. If Minimum Expectations are not met, the rotation must be repeated using away elective time. This will include mixture of clinic, modules, and at least one call.

SCHOLARLY ACTIVITY AND RESIDENT PRESENTATIONS (PGY1, PGY2, PGY3)

Core Competencies:

At the completion of residency training, a family medicine resident should:

- Demonstrate the ability to ask answerable questions applicable to the direct clinical care of their patients. (Medical Knowledge)
 - Demonstrate the ability to search, find, and appraise both primary and secondary information sources for answers to these clinical questions. (Practice-based Learning and Improvement)
 - Demonstrate the ability to apply this information to the care of patients. (Patient Care)
- 3

- Complete a scholarly project. (Medical Knowledge, Interpersonal and Communication Skills).
- Demonstrate knowledge of the principles of ethics as it applies to medical research. (Professionalism)

ACGME Program Requirements stipulate:

“The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

Residents should participate in scholarly activity. Residents should complete two scholarly activities, at least one of which should be a quality improvement project.”

Our program meets this requirement through the following activities:

Critical Evaluation of Medical Literature

During all three years of residency training, residents receive instruction in the critical evaluation of medical literature during the monthly Journal Club. Residents take turns presenting articles and providing critique with the support of the residency faculty.

Quality Improvement Project

Residents are required to complete a Performance in Practice Module (PPM) which also fulfills the ABFM Part IV module requirement. Each physician will assess his or her care of patients using evidence-based quality indicators. After a physician enters patient data into the ABFM Website, feedback is provided for each of the quality indicators. The performance data is used by the physician to choose an indicator for which a quality improvement plan will be designed. Using a menu of interventions available from various online sources, the physician designs a plan of improvement, submits the plan, and implements the plan in practice. After a minimum of 1 week, the physician again assesses the care provided in the chosen health area and enters the data into the ABFM Website. The physician then is able to compare pre- and post-intervention performance, and compare their results to those of their peers.

Resident Presentations

Our program requires two formal presentations of each resident during their training as part of scholarly activity. This is in addition to service related presentations, such as Perinatal M&M and inpatient teaching activities. Other options for scholarly activity are found below. Faculty advisors are available to assist residents in the preparation for their formal presentations. The core faculty physicians will evaluate the presentations in terms of relevancy and quality.

Presentations that score marginally or do not adequately meet the objectives as outlined below may result in the need for an additional presentation at the discretion of the program director.

Primary Care Case Presentation:

During the second or third year, each resident is required to present a primary care case with which they have been clinically involved.

- a. The case may come from the health center or hospital service
- b. After describing how the patient presented to the clinic or hospital, the resident will then ask fellow residents what additional information they would like to know such as history, exam, labs, etc. with an emphasis on keeping the conference interactive. The resident may request a scribe to write this information on the board
- c. The case should be relevant to family medicine and the amount of detail appropriate, neither too detailed nor superficial
- d. In addition, the resident may invite specialists to elaborate on specific aspects of the case
- e. Following the presentation, the resident will discuss the following aspects of the case as applicable:
 - Epidemiology
 - Clinical presentation
 - Diagnosis
 - Treatment
 - Prognosis
 - Prevention
 - Screening summary
- f. The use of Power Point or overhead transparencies is encouraged to facilitate learning along with handouts
- g. Key learning points should be summarized at the conclusion of the talk
- h. Presentation should take around 45 minutes with 15 minutes for questions

Senior Grand Rounds:

All third year residents must prepare and present a Grand Rounds lecture to the hospital medical staff. Their academic advisor or alternate faculty member will provide assistance and consultation for the presentation.

1. Presentations must include a thorough and critical review of the medical literature with at least 10 references sited in the bibliography.
2. As appropriate during the presentation, the resident will make references to studies in the medical literature that support or refute assertions made during the talk.
3. The resident should prepare a handout, consisting of at least an outline to provide a reference for attendees.
4. The presentation should be done on Power Point.
5. Technical assistance is available through the hospital library and/or faculty advisors.
6. Grand Rounds at Mercy Medical Center Redding occurs on Friday at noon.
7. Residents will coordinate the date for their grand rounds presentation with Dr. Namihas late in the second year or beginning of the third year.

Alternative Scholarly Activities:

1. **Research.** As an alternative to presenting to the hospital medical staff, a senior resident with prior approval from the program director may participate in an active research program which gives the resident an awareness of the basic principles of study design, performance, analysis, and reporting, as well as of the relevance of research to patient care.
2. **Presentation at a national, regional, state, or local meeting.** This must involve a medical audience of larger scope than just the residents and faculty members. Such presentations must be approved ahead of time by the program director and attended by the academic advisor or his/her designee. Presentations must include a thorough and critical review of the medical literature concerning the topic, with at least 10 references cited in the bibliography.

RURAL FAMILY MEDICINE (PGY2)

A. Core Competencies:

At the completion of residency training, a family medicine resident should:

- Be able to discuss the issues of social determinants of health, health equity, social justice, and US policy impacts in the distribution of health services in low-resource settings. (System-based Practice)
- Assess the health care and public health needs of communities and make evidence-based decisions about resource allocation and the delivery of population health services. (Medical Knowledge, Patient Care)
- Demonstrate knowledge of effective advocacy strategies for health systems improvement within the rural context. (Interpersonal and Communication Skills, System-based Practice)
- Tailor health outreach and clinical interventions by taking into consideration local socioeconomics, politics, health disparities, and cultural influences. (System-based Practice)
- Demonstrate the ability to communicate effectively and collaborate with the patient, the patient's family, and the patient's caregivers with sensitivity to sociocultural and health literacy issues so that the diagnosis and plan of care are clearly understood and pertinent to their specific situation. (Interpersonal and Communication Skills)
- Demonstrate the ability to use interpreters when the physician and patient cannot speak the same language. (Interpersonal and Communication Skills)
- Create treatment plans based on knowledge of rural influences, utilizing resources that include local, state, and federal agencies as applicable. (System-based Practice, Practice-based Learning and Improvement)
- Recognize his or her own practice limitations and seek consultation with other health care providers and systems resources to provide optimal care within a rural construct. (Practice-based Learning and Improvement, System-based Practice)
- Develop the following general competencies in rural medicine including:

- a. Adaptability – how to shape one’s skill set to the needs of the rural community
- b. Improvisation – how to deliver quality care within the resources and skills you have available in
- c. the moment
- d. Life-long learning – how to continually acquire additional knowledge and skills as needed
- e. Collaboration – how to get help from others and work together
- f. Endurance – how to sustain oneself in rural practice

C. Service Goals:

Each resident will experience rural family medicine in order to understand the unique challenges of such practice (clinical and operational) and to be able to better decide if a rural practice fits their career interests.

D. Service Description:

Second year residents have the opportunity to request the locations for this four week rotation including: 1) Siskiyou Medical Group (Mt. Shasta) and Lassen Medical Group (Red Bluff) 3) Other sites including Shasta Community Health Center and Weaverville are being developed. To broaden experiences and exposure to various practice sites, two separate locations may be selected during this rotation. Residents have the option of living in the mountain communities during the rotation or being reimbursed for daily commute miles. Residents will be scheduled in their family health center for continuity patients on Fridays and Mondays all day twice during the rotation, and will participate in some hospital call at MMCR.

E. Duties:

Residents see patients in the ambulatory practices and in the hospitals serving those practices under the supervision of the attending family physicians.

SURGERY ROTATION (PGY1, PGY3)

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Be able to perform a surgical assessment and develop an appropriate treatment plan. (Medical Knowledge, Patient Care)

- Coordinate ambulatory, in-patient and institutional care across health care providers, institutions and agencies. (Systems-based Practice, Patient Care)
- Demonstrate the ability to communicate effectively with the patient, as well as the patient's family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood. (Communication)
- Demonstrate the ability to communicate effectively with the surgeon supervisor/consultant about the patient's symptoms, physical findings, test results and proposed plan of care. (Communication, Professionalism)
- Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care. (Professionalism, Practice-based Learning)

B. Service Goals

The surgery rotations in the first and third years are intended to provide the family practitioner with appropriate diagnostic and management skills to recognize and appropriately refer the surgical patient in a timely fashion and to manage the medical and social issues of the surgical patient. Additional curricular resources and reading material can be accessed on the Family Medicine Residency Curriculum Resource at www.fammedrcr.com.

C. Service Description

Each resident will rotate on the surgical service for one month during his or her first and third years. The resident will be assigned to one surgical preceptor during the rotation. Their primary responsibility is to accompany and assist the surgeon with clinic and in-patient responsibilities. Surgical assisting is a valuable component of the rotation, but the extent will be determined in part by the resident's future practice and the surgical privileges desired. The resident's call responsibilities will be the same as other residents scheduled for inpatient call. Depending on the surgical attending, residents may participate in trauma call with the surgeon.

D. Duties

- Provide surgical assistance to their respective preceptors.
- Accompany the surgeon in both out- and in-patient rounds
- Attend FHC continuity clinic, noon conferences and post-call time off. Continuity clinic will be one half-day per week for first years and 4 half-days per week for third years.

URGENT CARE

A. Core Competencies

At the completion of residency training, a family medicine resident should:

- Demonstrate an ability to rapidly assess and gather information pertinent to the care of patients in an urgent and emergent situation and develop treatment plans appropriate to the stabilization and disposition of these patients. (Patient Care, Medical Knowledge)
- Be able to identify the indication and perform procedures appropriately for the stabilization of the patient in an urgent and emergent care setting. (Patient Care, Medical Knowledge, Practice-based Learning and Improvement)
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care). (Systems-based Practice)
- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns. (Practice-based Learning and Improvement)
- Appropriately inform, educate, and elicit patient and family participation in medical-decision making in a professional and caring manner with sensitivity to cultural and ethnic diversity. (Professionalism, Interpersonal and Communication Skills)

B. Service Goals

The goal of this rotation is to prepare residents to effectively manage acute medical, procedures, and minor surgical conditions in outpatient centers and to seek consultations appropriately.

C. Service Description

The Urgent Care rotation consists of a one to two-week block at SCHC during the 3rd year.

D. Duties

The resident is generally scheduled from 8am – 5pm Monday through Friday with scheduled time out for the FHC continuity clinics, noon lectures, and post-call.

UROLOGY (PGY3)

C. Core Competencies

At the completion of residency training, a family medicine resident should:

- Have an understanding and working knowledge of the incidence, predisposition, and impact of diseases affecting men of different age groups, demographic groups, and geographic distributions. (Medical Knowledge)
- Understand the attitudes toward general health and preventive services that prevail in the male population. (Medical Knowledge, Patient Care)
- Be able to take a comprehensive men's health history, including occupational, behavioral, relational, and sexual history. (Medical Knowledge, Patient Care, Interpersonal and Communication Skills)
- Be proficient and comfortable performing a comprehensive male physical examination, including a urogenital, rectal, and prostate examination. (Patient Care)
- Be proficient in communicating in a sensitive and cogent manner with the patient and others involved in his care (when appropriate) all aspects of diagnosis and treatment. (Interpersonal and Communication Skills, Patient Care, Medical Knowledge)
- Understand and be able to communicate appropriate and relevant recommendations regarding screening guidelines, health maintenance, preventive services, and health system access in a way that is appropriate to male patients. (Patient Care, Interpersonal and Communication Skills, Systems-based Practice)
- Be knowledgeable about local resources that are available to assist in assuring appropriate services to male patients. (System-based Practice, Patient Care)
- Be open to feedback and willing to modify one's approach in order to provide a more male-friendly practice. (Practice-based Learning and Improvement, Interpersonal and Communication Skills, Patient Care)

D. Service Goals:

The goal of this rotation is to prepare the resident to enter practice with the knowledge, attitudes and skills to effectively evaluate urologic conditions, initiate management and seek consultation when appropriate.

C. Service Description:

The urology rotation is integrated into the third year of residency rotation along with Ophthalmology, Cardiology, and ENT. The Urology component is designed to expose residents to the evaluation and management of common urologic conditions that present in the ambulatory setting. The experience is based in a urology group practice with case based, one on one teaching. Where appropriate to accomplish educational goals, residents may accompany urology preceptors into the hospital setting to assist or observe surgical procedures. This rotation represents one component of a residents training in urology. Substantial training in the primary care of patients with urologic conditions is received in the Family Practice Center. Responsibility for the medical management of inpatients with urological complaints occurs throughout residency training.

D. Duties:

Attendance at the Urologist's office is scheduled by the Residency Coordinator's office. During this time you will work one-on-one with an Urologist. Continuity clinic time is maintained throughout the rotation at the minimum of four half-days/weeks.

III. Policies and Procedures

- For general personnel policies and procedures please refer to Mercy Medical Center Redding North State Service Area Human Resources Policy Manual. Copies of this manual may be located in the Human Resources Department or by signing into a hospital computer using single sign-on and selecting the Everyday Use MMR Icon.
- Policies relating to residency training may be modified to meet requirements and policies of the American Board of Family Medicine and the American College of Graduate Medical Education

ACADEMIC COUNSELING:

The residency program believes strongly in the partnership for learning approach between faculty and residents. Feedback to the residents on their performance, their accomplishments, and the areas of needed study is an important part of that partnership. Each resident has an Academic Counselor who is a member of the Core Faculty at Mercy Family Health Center... You will meet with this advisor throughout your three years of training, and his/she is committed to making your experience here the most productive possible. Your advisor will also be your advocate and someone to turn to if you are encountering problems during your time with us.

Goals of academic counseling are:

- To improve communication between residents and faculty,
- To allow residents an opportunity to voice concerns about their own educational needs and about residency teaching,
- To provide feedback to residents on their progress and performance,
- To provide a regular format to discuss problems and develop plans to correct these.

Process: Each resident will meet with the assigned faculty person two times during the year. Meetings will be scheduled in advance at a mutually acceptable time and should last about a half hour. A summary of the meeting written by the faculty person using the Academic Counseling Report will be entered in the resident's file after being read by the resident. The resident may also wish to write a short statement to be included. Items to cover may include:

- Review of preceptors' evaluation of resident including core competencies
- Discussion goals and plans after residency
- Discuss elective planning and opportunities
- Review of resident's procedure log and intern checklist (for first years)
- Review family practice clinic data including
 - individual and clinic productivity, financial performance
 - continuity of care data including obstetrical care, SNF visits, and home visits
 - medical records chart audit
- Discuss moonlighting policies and opportunities

- Review on-going leadership experiences
- Review of ABFP In-Training Assessment scores (including plan of study for identified areas of deficiency)
- Discussion of academic problems residents may be encountering
- Summarize areas of needed improvement
- Provide an overall performance evaluation of satisfactory, unsatisfactory, or marginal

ADMITTING PROCEDURES:

Hospital and Medical Staff Policies can be found on all hospital computers under the Policy Manager icon and/or the Medical Staff Service Department.

Every effort should be made to determine the patient's primary care physician at the time of admission. The primary care physician and the continuity resident as appropriate (both referred to as the PCP) should be advised of every admission to a residency service within the first day of hospitalization. Once this is accomplished, the following flow chart should be your guide:

Mercy Family Health Center Admissions: see MFHC Policy and Procedures

Mercy Maternity Clinic: see MMC Policy and Procedures

Newborn Nursery:

- When delivered by a resident's continuity OB, patient goes to the Family Practice Service: The FPS resident has the overall responsibility for the newborn, but the primary care physician (PCP) is expected to see his/her patients and write a note daily while they are in-patients, and see the mother. Exceptions will be made for out-of-town rotations, vacations, and weekends when not on call.
- Delivered from MMC, goes to Pediatrics Service to be managed by the team.

Unassigned admits from the ED:

- When the service is open to admissions, approximately every other medicine admission of an unassigned patient from the ED will go to the Residency Service
- Pediatrics and OB admissions will go to the services as appropriate
- Surgical specialty patients who are unassigned will not go to the Residency services
- The supervising attending should be notified as soon as possible re the admission, and immediately if patient is in any way critical or will be admitted to ICU or CCU. Resident physicians will be called to the Emergency Room to admit patients whom the ER physician has determined are candidates for admission.
- If the resident determines that in his/her opinion the admission is not necessary, the patient may not be discharged from the Emergency Department until having been personally evaluated by the resident's supervising preceptor. The preceptor is required to communicate that decision directly to the ER physician on duty.
- Transmit orders in a timely fashion.

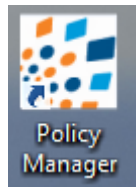
With the increasing volume of ED patients, and the occasional need to be On Diversion, a timely assessment of the admission in the ED is essential.

ADMISSION STATUS

The decision for admission status to the hospital is a complex medical decision based on the provider's judgment and the patient's need for medically necessary care. The patient placement order must be completed or co-signed by a provider with admitting privileges at Mercy Redding; the attending of service must sign the order to admit.

ADVANCE DIRECTIVES & RESUSCITATION STATUS:

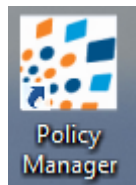
These hospital policies are located in the in Policy Manager. Policy Manager is located on all hospital computer desktops under the following tab:



Specific can be accessed d via folders or using the search option at the top of the screen.

APPEARANCE:

Your appearance has a significant impact on how others view you personally, gauge your professional competence, and judge the residency and hospital. Residents will present a professional appearance during working hours in compliance with Mercy Medical Center Attire Policy and Dress Code. These hospital policies are located in the in Policy Manager. Policy Manager is located on all hospital computer desktops under the following tab:



Specific policies can be acced via folders or using the search option at the top of the screen.

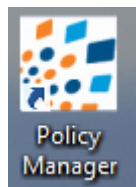
ANNUAL PROGRAM EVALUATION (APE) AND PROGRAM EVALUATION COMMITTEE

1. The Residency will establish a Program Evaluation Committee (PEC) which will:
 - a. Plan, develop, implement and evaluate the educational activities of the program.
 - b. Review and make recommendations of revision of competency based curricular goals and objectives.
 - c. Address areas of non-compliance with ACGME standards and citations.
 - d. Annually assess the effectiveness of the program's education of residents using evaluations of faculty and residents.
2. The PEC includes all core faculty along with the chief and assistant chief residents.

3. The PEC will meet annually at the Annual Planning Meeting and more often as necessary
4. The PEC will document formal, systematic evaluation of the curriculum and is responsible for rendering a written Annual Program Evaluation (APE).
5. The PEC will create an action plan for the each academic year.
6. The APE will be developed by the PEC at the Annual Planning Meeting and presented in the form of a summary, meeting minutes, and Action Plans to the GMEC for approval:
 - a. Faculty Development
 - b. Review Action Plans from Prior Year
 - c. ACGME Citations
 - d. Mercy Annual Internal Program Evaluation
 - i. Resident Survey
 - ii. Faculty Survey
 - e. ACGME Surveys
 - i. Resident ACGME Survey
 - ii. Faculty ACGME Survey
 - f. ABFM Exam Take and Pass Rates
 - g. Resident ITE Performance
 - h. Resident Encounter Data
 - i. Graduate Survey
 - j. Resident Attrition
 - k. Curriculum Review
7. The GMEC Committee will review the APE. As a single program institution, the APE will be an essential component for developing the Annual Intuitional Review (AIR) Action Plans

AUTOPSIES:

These hospital policies are located in the in Policy Manager. Policy Manager is located on all hospital computer desktops under the following tab:



Specific policies can be acced via folders or using the search option at the top of the screen.

BALINT GROUP/ RESIDENT WELLNESS/ INTERN CONFERENCE:

All interns meet every 1-2 weeks during the first 6 months and 1-2 times per month for the last 6 months with Jay Roitman and Christine Woroniecki for a one-hour conference. Every other session is devoted to clinical topics as part of the program's commitment to achieving PGY 1 clinical competencies. These topics include common outpatient clinical diagnoses and care management issues including health care maintenance, diabetes care, hypertension, asthma/COPD, respiratory infections, hyperlipidemia, pharmacology and prescriptions, cost effective healthcare, etc. These sessions help orientate the first year residents to a comprehensive approach to health care and promote the resident identify as a family physician. The other conferences consist of a modified "Balint" group discussing issues that affect all of us as physicians, but especially interns. Examples would include the "difficult" patient, death and dying, frustrations and sources of satisfaction as well. The purpose is to develop a forum for sharing and understanding, not correcting or advising! All discussions are held in strict confidence among the participants.

ACGME requires programs to have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. This is accomplished through various means, including academic advisor meetings, monthly meetings involving the residents, program director, and clinic staff. Residents also receive training on fatigue, well-being, and impairment during their Annual Hospital Staff Education and lectures provided by Behavioral Science Coordinator, Dan Rubanowitz, PhD. Other regular lectures include Communicating with Compassion (Dr. Lupeika), Progressive Muscle Relaxation / Stress Management (Dr. Rubanowitz) and Dialogue with Duane (informal monthly meetings with program director),

The ACGME also requires a structure and facilitated group designed for resident support that meets on a regular schedule. For the first year residents, this is accomplished in the regularly scheduled intern conferences. For second and third year residents, a support group facilitated by Dr. Paul Davis meets on a regular basis. This group is specifically designed for resident support, promotion of physician well-being, and prevention of impairment. Dr. Rubanowitz also coordinates an Annual Wellness Screening and Consultation for all residents. This involves assessing the individual resident's score on the Professional Quality of Life Scale, filling out a Wellness and Physician Impairment Prevention check list (see below), and participation in facilitated discussions. This occurs on an individual basis in PGY1 and via group session during PGY2-3 (with an option for individual sessions).

RESIDENT WELLNESS AND PHYSICIAN IMPAIRMENT PREVENTION CHECKLIST

The following items were presented for review and basic education, with an opportunity for discussion, additional information, follow-up, and/or referral resources:

- Professional Quality of Life Scale: Completed, Scored, Feedback Sheet Given
- Conceptual Model of Compassion Satisfaction/Compassion Fatigue Discussed
- Review/Discuss Work-Environment Stressors or Traumatic Experiences
- Review/Discuss Promotion of Collegial or Professional Peer Support System
- Review/Discuss Importance of Preventing Family Life Interference
- Health Behaviors: Sleep Hygiene
- Health Behaviors: Exercise
- Health Behaviors: Diet and Caffeine Management
- Health Behaviors: Substance Use and Abuse
- Health Behaviors: Rest, Relaxation, Recreation
- Review Health Care Benefits for Mental Health Services; Referral Options
- Review/Encourage Ongoing Availability of Informal Consultations (viz., Behavioral Science faculty, Faculty Advisor, Program Director).

Resident Name _____

Resident Signature _____

Date _____

In academic year 2017-2018, we are implementing two new programs. 1) The Mercy Redding Family Practice Residency Program along with Shasta Community Health Center Residency Program is beginning a monthly Resident Balint Group facilitated by Dr. Ron Sand. 2) Dignity Health has implemented the Resident Fellow Well-Being Index on-line tool. This tool includes a seven-question survey based upon validated research conducted by the Mayo Clinic. The purpose is to provide an estimate of current well-being level and provide useful resources for follow-up.

Every core faculty member is available to provide individual discussion, consultation and referral for any Resident experiencing wellness related concerns. The Behavioral Science faculty members are available for additional, more individualized wellness-educational consultations as needed for each and every Resident during the course of their training. Residents also have access to the Employee Assistance Program (EAP):

Anthem's Employee Assistance Program (EAP) is a confidential information, support, and referral service offering tools and resources designed to help maximize productivity and meet the challenges of modern life. As an employer-sponsored program, EAP services are available to employees and their household members at no additional cost to them. Areas frequently addressed by the EAP include:

- *Child care and parenting*
- *Helping aging parents*
 - *Financial issues*
 - *Legal concerns*
 - *Work and career*
- *Emotional well-being*
- *Addiction and recovery*
- *Wellness and prevention*
- *Concierge and convenience services*
 - *Life events*

*The **Employee Assistance Program** can be accessed by calling: 800 999-7222 or on the web at www.anthemeap.com (enter Dignity Health to log in). Free, confidential help 24 hours a day, 7 days a week.*



Resident Wellness Post Call

To promote resident wellness for residents who are too tired to drive home post-call, the residency program has set up the following policy:

- During the week, residents can call the residency office at 225-6090 to arrange for a ride home.
- During the weekend, the jeopardy resident can be contacted for a ride home if needed. If the jeopardy resident is unavailable, a resident may call for a taxi and will be reimbursed by the residency office.

BOARD CERTIFICATION:

For board certification, graduates of the residency program must meet the eligibility criteria specified by the American Board of Family Medicine (ABFM). Per the ABFM, these include:

1. Completion of 50 Family Medicine Certification points
2. Application and full examination fee for the Family Medicine Certification Examination (the residency programs cover half the cost of exam fee if taken during residency)
3. Attainment of an active, valid, full, and unrestricted license to practice medicine in any state or territory of the United States or any province of Canada and be in continuous compliance with the ABFM Guidelines for Professionalism, Licensure, and Personal Conduct

4. Successful completion of family medicine residency training and verification by the program
5. Successful completion of the Family Medicine Certification Examination

Additional information on board certification may be found at www.theabfm.org.

CHIEF RESIDENTS:

The Chief Residents are key members of the residency program whose leadership, advice to the faculty and program director, and hard work makes the program strong. As an elected representative of the residents, the chief resident deserves the respect of both faculty and residents. At times, the chief resident may participate in confidential discussions involving residents or faculty. Examples include participation in the weekly faculty meetings and discussion of an individual resident's performance and progress and how this may affect his/her responsibilities and the residency program schedules.

Electing the Chief: There are two overlapping terms of chief resident office: July 1-June 30 and January 1 – December 31. The Chief must be an R-2 in good standing when elected, receiving a majority of resident votes with final approval by the program director. The overlap allows for smooth transitions as well as back-up functions when one of the chiefs is away.

Chief Resident Duties: The two chiefs share the duties, with responsibility for the schedule assumed by each during the last six months of their terms.

- Administrative representative of residents (provided with appropriate administrative time to accomplish his duties)
- Coordinator of resident complaints
- By example, foster the public and professional image of family practice and our program
- Attends FP Residency Committee and other Medical Staff meetings as invited by Program Director
- Prepares Master Schedule with input from residents, health centers, and residency coordinator with final approval by the Program Director
- Prepares call schedule with input from residents and core faculty
- Provides first contact with acutely ill residents to facilitate coverage
- Oversees jeopardy call system.

The Chief Resident may schedule 4 hours of administrative time per four week rotation, which must be scheduled in advance and cannot accumulate or be carried over to the next month.

CLINICAL COMPETENCY COMMITTEE

Introduction

The Mercy Redding Family Practice Residency Program regularly collects information on residents for the purpose of performance improvement and to ensure delivery of safe patient care. This information is reviewed by the Clinical Competency Committee (CCC). The creation of the CCC is mandated by the ACGME as part of the Milestone evaluation process. The members of the CCC make a consensus decision on the Milestone achievements of each resident using multiple sources and types of resident assessments. The CCC determines how well a resident is meeting program standards and progressing along an expected educational trajectory. This process provides an opportunity for ongoing educational feedback and early identification of competency issues and helps to shape resident performance improvement and remediation plans. CCC members will conduct themselves in a professional and respectful manner and provide honest, constructive evaluation and feedback for all residents. Decisions will be made by consensus. If consensus cannot be achieved, the issue will be referred to the Program Director. Proceedings of the CCC are confidential.

Membership

- 1) The CCC will be selected by the program director and have a minimum of four members, including the following individuals (all are voting members except the program director):
 - i) CCC chair (A core faculty member who is not the Program Director)
 - ii) Two additional core faculty
 - iii) Other core faculty, non-core faculty, and non-physician members of the health care team as assigned by the program director
 - iv) Program director

Role and Responsibilities of Members

1. Review resident evaluations semi-annually (semi-annual review deadlines are in January and July of each calendar year)
2. Review & assess each resident in the six core competency areas on entrance into the program (CCC will meet by the end of August)
3. Assign a CCC member who will preliminarily review and present the resident at CCC
4. Determine proper weighting of each performance measure (utilization of the Milestones will involve comparisons to peers as well as national benchmarking data when available)
5. Prepare and assure the reporting of required semi-annual Milestones evaluations to the ACGME (The residency administration and support staff will provide the necessary review materials and assist with ACGME reporting)
6. Advise the Program Director regarding resident progress, promotion, remediation, and dismissal. Example recommendation may include:
 - i. Assigning a mentor with expertise in a given area of deficiency
 - ii. Additional required study, readings, question sets, oral cases, etc.
 - iii. Sessions in a skills lab or addition of selected rotations
 - iv. Extension of residency training
 - v. Residency termination

Measures of Performance

The CCC will use explicit assessment data to measure resident performance including the following:

- ABFM In-Training Exam
- ABFM Maintenance of Certification
- Advisor Semi-annual Summative Evaluation
- Annual Compliance & On-line Education Training
- Behavioral Science Direct Observation
- Board Exams – Part 1, 2, and 3
- Leadership Committee Participation
- Life Support Training – ACLS, ALSO, BLS, NALS
- Mercy Family Health Center Preceptor Evaluations
- Mercy Medical Center PGY1 Check list
- Patient Chart Audits
- Presentations - Primary Care, Grand Rounds, Journal Club
- Procedure Performance Evaluations
- PPMP (CLIA) Certification Exam
- Resident Peer Evaluations
- Rotation Evaluations

CONFERENCES:

Noon conferences occur Monday - Friday on non-holidays, from 12:30 - 1:30 pm., in conference rooms C and D, unless indicated otherwise in the monthly schedule. The residency office sends out the schedule for each 4-week block. The schedule indicates the topic, speaker, location and whether lunch is provided. If lunch is not provided, residents may obtain their lunches from the cafeteria and bring them to the conference.

The noon conference curriculum features talks covering a variety of medical specialties on a one to three year rotating schedule. Other conferences include the following:

Resident/Faculty Meeting	Bi-Monthly
Resident Meeting	Monthly
FHC Resident/Staff Meeting	Bi-Monthly
Perinatal (OB and Peds) M&M	Monthly with resident case presentation
Senior Resident Grand Rounds	One for each senior resident/year on Fridays
Primary Care Case Presentation	Monthly given by PGY2s and PGY3s
Dialogue with Duane	Bi-Monthly with residents and Dr. Bland

In addition to noon conference, Morning Report occurs on Wednesdays 7:15-8:00 a.m. with the following structure:

- *Presenter-presents and prepares teaching points*
- *Moderator-keeps discussion and questions going-writes on board*
- *Present without stopping: Chief complaint, HPI, ROS*

- *Break for questions about CC/HPI/ROS*
- *Present without stopping: Allergies, Meds, PMH, Surg Hx, FH, SH*
- *Break for questions about Allergies/Meds/PMH/Surg Hx/FH/SH*
- *Create a Differential Diagnosis with Moderator*
- *Present without stopping: Physical Exam*
- *Moderator asks Residents for labs and studies they want*
- *Present labs and studies as requested*
- *Revisit and revise Differential Diagnosis*
- *Present final diagnosis, Order set, and What floor to admit to and why*
- *ADCVANDALISM*
- *Present Evidence based guidelines and novel treatments*
- *Summarize Take Home Points for disease (ie-work up and treatment, key facts, 2am calls and what to do)*
- *If handout is done, this will be put in Library in Morning Report Binder for future reference*

Although residents may need to attend to urgent patient care needs, prompt and regular attendance of conferences is expected for all residents. Most speakers have put a great deal of effort into preparing their talks and their time should be respected. Residents who attend less than 50% of conferences over a four month average will be assigned to provide a talk for intern conference.

Residents and faculty members may offer suggestions for conference topics to the noon conference coordinator, Steve Namihas, MD.

CONTINUITY POLICY

The Mercy Redding Family Practice Residency Program considers continuity care to be an integral component of family medicine and residency education. As health care team members, we also recognize that coverage for colleagues who are unavailable (due to illness, vacation, etc.) is imperative for timely and appropriate patient care. The following continuity policy has been established taking into consideration PTO, away electives and coverage for colleagues.

1. Clinic Continuity:

- a. The program has set a clinic continuity goal of at least 50% for each resident. FPS, C1 and C2 rotations will not be included in these calculations since the resident on these services are expected to see a greater number of work-in patients.
- c. The resident will be encouraged to take new patients into their clinic from hospital rotations and / or from the Orange New Patient sheets found in the preceptor room.
- d. If no improvement is noted in continuity the percentage the following month, the Clinic Management Team will begin to assign additional patients to resident from the Orange Sheets until the goal is met.

2. Hospital Continuity:

- a. The program has set a hospital continuity goal of at least 80% for each resident who has continuity patients in the hospital receiving care on the Family Practice Service. Residents will be excused if out of town.

- b. If the goal is not met as determined by quarterly audit, the resident will be scheduled to give a noon conference case presentation on one of his or her patients.

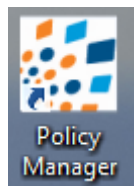
COUNTERSIGNATURE REQUIREMENTS FOR RESIDENT CHARTS:

Per Medical Staff Policy Statement on Graduate Medical Education Program Supervision of Residents:

The attending physician is responsible to round with the resident team everyday he/she is on service. The attending physician is responsible to review the clinical records of all patients on his/her service, checking the work-up and progress notes of the residents. This monitoring should include attention to the resident's ability to structure a differential diagnosis and diagnostic plan, review of therapeutic options and approval of all medications and therapies prescribed by the resident. The attending physician is responsible for signing off on the clinical records including discharge summaries of all patients admitted to their service. The attending physician will complete a brief admission note or authenticate the residents' admission note within 24 hours of admission. H&Ps will be authenticated by a preceptor within 24 hours. For all admissions, the attending will review the resident progress notes daily and authenticate or complete a separate note. Individual orders, including orders for initiation or renewal of patient restraints, are monitored by the attending physician. For billing it is the attending physician's responsibility to follow insurance (i.e. Medicare, Medi-Cal, etc.) requirements for supervision and documentation.

CONSENTS AND RELATED MATTERS:

Up to date information of consents may be found in the Informed Consent Policy and/or California Hospital Association (CHA) Consent Manual. The consent manual is located in Risk Management Services, Health Information Management, Emergency Departments, and Mercy Family Health Center. Hospital policies are located in the in Policy Manager. Policy Manager is located on all hospital computer desktops under the following tab:



Specific policies can be accessed via folders or using the search option at the top of the screen.

CRITERIA FOR ADVANCEMENT/PROMOTION OF RESIDENTS IN FAMILY PRACTICE:

The decision to promote a resident each year shall be determined by the Residency director with the advice of the promotions board, Clinical Competency Committee, and faculty. The method

of evaluation shall consist of direct observation of the resident as well as by indirect observation through videotapes, rotation evaluations, and written examination (National Boards, In-training exams, etc.). It is expected that residents will participate in all aspects of the curriculum, as well as in the periodic evaluation of educational experiences and faculty. It is further expected that residents will complete all administrative responsibilities of a resident, including medical records, licensure, credentialing, etc. in a timely fashion. Incorporated into the criteria for advancement are the ACGME's six core competencies and the Milestones. These are specifically included in the attending rotation evaluations and include:

- Patient Care
- Medical Knowledge
- Practice-based Learning/improvement
- Interpersonal/Communication Skills
- Professionalism
- Systems-based practice

To be promoted from the PGY1 to the PGY2 year, the resident must meet the promotions criteria outlined below, perform at a competency level adequate to warrant licensure in California, act with limited independence, and perform at a competency level to supervise junior residents and students. (These criteria are also applied to International Medical Graduates even though they cannot qualify for licensure in California until the completion of the PGY2 year). For promotion from the PGY2 to PGY3 year, residents continue to meet the PGY2 competency requirements listed above and meet the promotions criteria outlined below. To graduate, the resident must continue to meet the PGY 2 and PGY3 competency requirements, meet the promotions criteria outlined below, and be judged to have demonstrated sufficient professional ability to practice competently and independently as a family practice physician.

The Promotions Board is composed of six voting members, three faculty, appointed by the residency director, and three residents. One resident is elected from each class to sit on the Board. The Board meets annually in January and as needed thereafter to review each resident and recommend to the residency director for or against promotion to the next level of training. The following criteria are used by the Board in their deliberations.

Major criteria: These criteria must be met to be promoted to the next year of training.

- Receive at performance rating of average (3) or better on the Family Practice In-patient and Family Practice Clinic rotations and receive a majority of performance evaluations showing sub-competencies are at the expected PG level (1-2 for PGY1, 2-3 for PGY2, and 3-4 for PGY3). Meet the following licensing requirements:
 - USMG: Pass USMLE or NBOME part 3 before the end of PGY1. Have California license application submitted by the beginning of PGY2. Obtain California medical license by the end of PGY2. (See separate **Licensure** section for policies on reimbursement etc.)
 - IMG: Pass USMLE part 3 before the end of PGY2. Have California license application submitted by the beginning of PGY3. Have California

license by the end of PGY3. (See separate **Licensure** section for policies on reimbursement etc.)

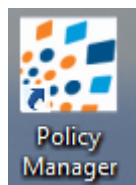
- A positive Faculty Advisor's report. Faculty Advisors shall meet with all residents at least every six months. If satisfactory progress is not noted, or if problems are identified, additional meetings may be scheduled on a more frequent basis with regular reports to be submitted to the Faculty Committee.
- Complete, or provide evidence of progress, the resident's third year grand rounds presentation. Determination of progress will be the decision of the resident's faculty advisor.
- Satisfactory participation in all required activities of the training program; including nursing home visits, FPC resident/staff meetings, noon conferences, continuity care of patients admitted to hospital, etc.
- Attend all rotations as scheduled
- Be competent to function independently and in a supervisory role with junior residents. The faculty committee will make this determination.
- For graduation, demonstrate sufficient professional ability to practice competently and independently as a family practice physician. The faculty committee and program director will make this determination.
- Abide by standards consistent with expected professional and ethical behavior.

Minor Criteria: These criteria will also be considered by the Promotions Board in determining a resident's readiness for promotion. They are not necessarily required for promotion, but may effect promotion based on individual circumstances the achievement of other major and minor criteria.

- In-training Assessment Examination composite score at or above the 20th percentile for post-graduate year.
- Satisfactory evaluations by Family Practice Center nursing, office staff and peers.
- Receiving a performance rating of 3 (average) or better on non-family practice services and community rotations.

DEATH RELATED ISSUES:

Information and hospital policies Deaths can be found under hospital policies. These hospital policies are located in the in Policy Manager. Policy Manager is located on all hospital computer desktops under the following tab:



Specific policies can be accessed via folders or using the search option at the top of the screen.

Residents must be licensed senior residents in order to declare death.

- Death Certificate Guidelines:
 - DO NOT PUT "CARDIO-RESPIRATORY FAILURE" or, "Cardio-respiratory collapse" for the cause of death.
 - The first line of the "Cause of Death" section is the disease or trauma that caused the death, e.g. myocardial infarction, **NOT** common final pathways like cardiopulmonary failure, etc.
 - The second line is for secondary causes, e.g. Atherosclerotic Cardiovascular Disease, trauma
 - The third line is for tertiary causes, if any. The contributing factors can include things like smoking or diabetes. Please be sure there is documentation for the cause(s) mentioned, and touch base with any faculty person if you have any question about what to include in the certificate. Your attending or Dr. Nena Perry will be happy to help you with any questions.

DOCUMENTATION OF RESIDENCY EXPERIENCE:

A comprehensive documentation of your residency experience is important to your future practice as a family physician. The information you collect will provide a basis of documentation when requesting hospital privileges and malpractice. Educational content of your training, board certification, as well as experience with specific diagnoses and procedures will all be considered when medical staff membership is granted. All residents are required to document procedural experiences using New Innovation on-line procedure logger. In addition, this program should be used to document patients seen in the ICU, SNF, and home visits. The ACGME also requires tracking of specific patient encounter types (ie. Pediatric outpatient, Pediatric ED, etc.). These encounters are tracked using "Blue Cards" that must be turned into the residency office at the end of each rotations. Beginning in 2017, we are moving to an online data base to track encounters. Data on procedures and encounters may be used as a source of information for future reference letters, which may be requested by places of employment and hospitals from the residency program. It will also be used to provide data to regulatory bodies such as the ACGME and ABFP to confirm we are meeting the requirements for residency education in family medicine.

DUE PROCESS PROCEDURE FOR RESIDENCY PROGRAM

Introduction:

A number of administrative actions may affect the continued participation of a resident in the residency program. These include, but are not limited to: periodic evaluations; letters of counseling, warning, admonition, reprimand, and censure; probation; reduction of privileges; suspension from the residency program, which may include suspension of clinical privileges for medical record delinquency, or for other reasons; and dismissal.

Grounds for Disciplinary Action:

Grounds for disciplinary action include, but are not limited to, the following:

- Failure to rectify deficiencies of which the resident has been notified in one or more letters of warning, censure, probation, or suspension.
- Incompetence or conduct adversely affecting quality of patient care.
- Unethical or illegal conduct.
- Violation of standards of the residency program, or of the Bylaws or the Rules and Regulations of the Medical Staff of Mercy Medical Center.

Medical Record Delinquency:

Suspensions of clinical privileges, which arise from medical record delinquencies under the provisions of the Bylaws of the Medical Staff of Mercy Medical Center, shall automatically result in a like suspension of participation in the residency program, without right of hearing or appeal. Participation shall be reinstated upon reinstatement of clinical privileges pursuant to the Bylaws of the Medical Staff of Mercy Medical Center. Continued medical record delinquency may be cause for other disciplinary action.

Letters:

Letters of counseling, warning, admonition, reprimand, and censure shall be issued by the Residency Director when a resident's performance fails to meet the standards set by the training program. Receipt of such a letter requires that the resident physician correct the deficiency as presented within the letter. The letter shall stipulate the specific reasons for any actions noted and the recommended course for correction. If patient care activities are involved, a copy of the letter will be submitted to the Medical Director of Mercy Medical Center. Continued failure to correct the deficiencies may result in suspension or dismissal from the residency training program. Such a letter shall not give rise to a right to a review hearing or to appeal.

Temporary Suspension:

A resident physician may, without right to a review hearing, be temporarily suspended, for a period not to exceed ten (10) days, from participation in the residency program, including loss of clinical privileges, at any time upon the written, specific recommendation of a faculty member to the Residency Director if, after review, the Director, in his sole judgment and discretion, determines that patient care has been compromised or that the resident physician is involved in activity not otherwise appropriate to the program. During the period of temporary suspension, the Residency Director may review the resident's performance and determine whether or not additional disciplinary action should be taken against the resident.

The Residency Director may determine that suspension of a resident's privileges should remain in effect for a period in excess of ten (10) days. In that event, the resident shall be entitled to a review hearing and appellate review if requested by him in the manner prescribed.

The Residency Director may also determine that privileges should be suspended pending the review hearing and appeal process. In this event, the resident shall be entitled to a preliminary review of that decision as soon as it can be arranged before the Medical Director and the Chief of Staff of Mercy Medical Center. The decision of the Medical Director and the Chief of Staff as to whether or not suspension should remain in effect pending the review hearing and the appeal process shall be final and conclusive upon the resident.

Other Disciplinary Actions:

Disciplinary action other than or in addition to, temporary suspension or letters described in Section 4, may be recommended at any time by the Residency Director. The Residency Director shall notify the resident, in writing, of the proposed action which has been recommended, the reasons for the recommendation, and a summary of the resident's rights under the provisions of this due process procedure. Upon notification of the recommendation for disciplinary action by the Residency Director, the resident, within a period of ten (10) days, may request a review hearing by written request delivered to the Residency Director. In the event that the resident fails to request a review hearing, the recommendation of the Residency Director shall be submitted to the Family Practice Residency Committee for action, whose decision and judgment on the matter shall be final and conclusive.

Review Hearings:

Upon request by the resident for a review hearing, a Review Panel shall be convened within twenty (20) days. The resident shall be notified of the hearing date not less than (10) days prior to the review hearing. The notice of hearing shall include a list of the witnesses to be called in support of the recommendation of the Residency Director. The Review Panel will consist of five individuals, all of whom shall be faculty members of the residency program. The Medical Director of Mercy Medical Center shall select four members of the panel and the affected resident shall select one. At the hearing, the Residency Director on the one hand, and the affected resident on the other, will each have the right to call witnesses and present relevant verbal and written evidence of the sort that responsible persons are accustomed to rely on in the conduct of serious affairs. Evidence need not conform to common law or statutory rules, which might make it inadmissible in a court of law. The resident will be afforded the opportunity to present a personal statement in his or her own defense. The statement may be presented orally or in writing. The review hearing will be closed and the proceedings shall be recorded by a court reporter or by other means approved by the panel. Legal counsel may be consulted to assist in preparation for the hearing, but may not directly participate in its proceedings. The Review Panel shall render a recommendation, in writing, to the Family Practice Residency Committee within ten (10) days of the hearing. The recommendation shall include the reasons supporting the decision. A copy of the recommendation shall be delivered to the affected resident and to the Residency Director.

Appeal:

Following receipt of the Review Panel's decision, the resident may appeal that decision, in writing, to the Family Practice Residency Committee. To exercise that right he shall give written notice of his intent to appeal to the Residency Director within ten (10) days following delivery of the decision to him. Failure to give notice in the manner and within the time provided shall constitute a waiver of the right to appeal. Notice of the time and place of the appearance before the Family Practice Residency Committee, which shall be scheduled not less than twenty (20) days following the request for the appeal, shall be given to the resident not less than (10) days before the time scheduled. The proceedings on appeal shall be in- the nature of an appellate review, based upon the record of the hearing before the Review Panel. However, the Family Practice Residency Committee, in its sole judgment and discretion, may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Review Panel Hearing. The resident and the Residency Director shall each have the right to present oral and written statements and authorities at any time prior to submission of the matter, in support of his or her position on appeal. The Family Practice Residency Committee may affirm, modify, or reverse the recommended action of the Review Panel or may, in its sole judgment and discretion, refer the matter for further review and consideration. The decision of the Family Practice Residency Committee shall be final and conclusive.

Medical Staff Proceedings:

Nothing in this due process procedure shall be construed to prohibit the Medical Staff of Mercy Medical Center from taking disciplinary action against a resident in accordance with the provisions of the Medical Staff Bylaws. Suspension of the privileges of a resident or termination of his membership on the Medical Staff by reason of proceedings taken by the Medical Staff in accordance with the Medical Staff Bylaws of Mercy Medical Center, shall result in like suspension or termination from the residency program without any right to appeal, or without any right to review or appeal under this due process procedure.

Error in Procedure:

The Family Practice Residency Committee, in its sole judgment and discretion, shall determine whether or not any failure to follow the procedure outlined in this document has deprived a resident of due process, and should constitute grounds for a new review hearing and appeal or for other remedial action. Its determination with regard to that matter should be final and conclusive.

EVALUATIONS:

Evaluation and feedback are essential to knowing if we are meeting our intended goals. In the residency program, this is true for resident performance, teacher performance, curriculum composition, rotation performance, conference quality, and significantly, graduate assessment of

the effectiveness of their training. Evaluations may be formative, where feedback is given at the time of performance and helps to correct, or confirm, the appropriateness and effectiveness of the performance (e.g. you did that circumcision just right. The block could be improved by using a little more anesthetic). Evaluation may be summative, which occurs following input of all evaluation information and results essentially in a grade.

Resident Evaluations:

Attending Evaluation of the Resident - On each rotation, the appropriate attending(s) will complete the milestone based evaluation. These evaluations are performed using New Innovations.

Procedure Competency - Procedural competency evaluations are provided by the precepting attendings using New Innovations (see Procedural Competency section below).

Peer Evaluations - Resident have the opportunity to evaluate each other on the Medicine and Pediatrics/Ob services using the New Innovations on-line evaluation system. Junior residents evaluate senior in specific milestone competencies. These evaluations are anonymous. Senior residents also evaluate junior residents in specific milestone competencies. The senior residents are encouraged to review their evaluations directly with junior residents in addition to using the New Innovations on-line evaluation system.

Presentation Evaluations – Primary care case presentations provided by residents are evaluated by both peers and attending using new innovations. Third year Grand Round presentations are evaluated by core faculty in addition to a general audience evaluation performed by the Mercy Medical CME department.

Rotation Evaluations:

Rotation strengths, weaknesses and opportunities for improvement are incorporated into the attending evaluations. With New Innovations, this collated data is available for review during the Annual Program Evaluation in the spring. Based on these evaluations, program modifications are made for the upcoming.

Family Health Center Evaluations:

MFHC conducts a health center evaluation annually (and monthly for the Clinic Rotation), or more frequently as needed. Issues such as clinical material, office design and function, procedures and protocols, teaching and reference materials are included in this evaluation. In addition, there are health center management meetings held throughout the year with resident participation, to discuss important issues.

Conference Evaluations:

Conferences which are designated CME will include an evaluation form completed by the participants to track the quality and relevance of the material presented. These evaluations help determine the quality and relevance of lectures and the need for modification.

American Board of Family Practice In-training Assessment Exams:

In-training Assessment Exams are given to all residents in November, and residents must take the exam. If vacation or away electives have been scheduled for the same time, the resident must make appropriate arrangements with the Residency Coordinator to take the exam elsewhere, or return to Redding. Exams are similar to Board exams in content and format. . If the overall score is below the 20th percentile, moonlighting privileges may be forfeited pending improved performance on the next In-training Exam and/or a period of restudy and repeat examination. The scores will be another instrument for review and feedback on the resident's progress as well as on the overall performance of the program in order to identify any areas of program weakness.

Graduate Evaluation:

Graduates are surveyed every 5 years on the quality and relevance of their residency training. This has been done independently and in conjunction with the UC Davis Family & Community Medicine Network of Family Practice Residencies so that we are also able to compare program success. This information is vital to keeping our program relevant in our changing world of medical practice.

Informal and formal discussions

Informal discussions with the Program Director, faculty advisors, faculty and peers are valuable ways to improve the partnership of teachers and learners, and to improve the quality of care we deliver to our patients. Residents have the opportunity to provide feedback at regularly scheduled resident/faculty meetings, clinic staff resident meetings, and “Dialogue with Duane” meetings.

Milestone Evaluations

The Mercy Redding Family Practice Residency Program regularly collects information on residents for the purpose of performance improvement and to ensure delivery of safe patient care. This information is reviewed by the Clinical Competency Committee (CCC). The creation of the CCC is mandated by the ACGME as part of the Milestone evaluation process. The members of the CCC make a consensus decision on the Milestone achievements of each resident using multiple sources and types of resident assessments. The CCC determines how well a resident is meeting program standards and progressing along an expected educational trajectory. This process provides an opportunity for ongoing educational feedback and early identification of competency issues and helps to shape resident performance improvement and remediation plans. The

CCC will use explicit assessment data to measure resident performance including the following:

- ABFM In-Training Exam
- ABFM Maintenance of Certification
- Advisor Semi-annual Summative Evaluation
- Annual Compliance & On-line Education Training
- Behavioral Science Direct Observation
- Board Exams – Part 1, 2, and 3
- Leadership Committee Participation
- Life Support Training – ACLS, ALSO, BLS, NALS
- Mercy Family Health Center Preceptor Evaluations
- Mercy Medical Center PGY1 Check list
- Patient Chart Audits
- Presentations - Primary Care, Grand Rounds, Journal Club
- Procedure Performance Evaluations
- PPMP (CLIA) Certification Exam
- Resident Peer Evaluations
- Rotation Evaluations

FAMILY OR FRIENDS VISITING RESIDENTS AT HOSPITAL:

Issues professionalism, hospital policies, privacy, and HIPPA must be considered when residents have family members or significant others visiting for meals or during breaks on call. These visitations must be limited to non-clinical areas (i.e. cafeteria, resident lounge). Discussion of patient care issues should be avoided in their presence. While family members may visit, their presence should not interfere with the resident duties. In addition, family members and significant others must not sleep or nap in resident lounge or call areas.

FNP/PA STUDENTS:

Students rotating at Mercy Medical Center shall be under the direct supervision of an attending physician and comply with the affiliation agreement and medical staff guidelines.

GRADUATE MEDICAL EDUCATION COMMITTEE

(Family Practice Residency Committee)

The Graduate Medical Education Committee (GMEC) has the responsibility for monitoring and advising on all aspects of residency education. The committee will meet quarterly. A regular agenda with committee members and standing agenda items is included below:

Family Practice Residency Committee
June 18, 2015
GENERAL SESSION

Members include:

Program Director:
Program Coordinator:
Chief Resident:
Assistant Chief Resident:
Mercy Family Health Center Medical Director:
Mercy Family Health Center Manager:
Behavior Science Coordinator:
Mercy Maternity Clinic Manager:
SCHC Residency Director:
Representatives of In-Patient Services:

- *ED:*
- *FP:*
- *IM:*
- *OB/GYN:*
- *Pediatrics:*
- *Surgery:*

Quality Improvement:

☞ ☞

CALL TO ORDER:

MINUTES OF THE PREVIOUS MEETING

DATES:

UNFINISHED BUSINESS:

NEW BUSINESS

DEPARTMENT REPORTS:

STANDING AGENDA ITEMS:

- A. *ACGME Communications (including accreditation, change in residents #s, Clinical Learning Environment Review reports, Annual Resident Survey, Annual Faculty Survey, WebADS)*
- B. *Annual Evaluation and Improvement Activities*
 1. *Annual Institutional Review (AIR)*
 - i. *Self-Study Visit Results*
 - ii. *ACGME notification of accreditation status and self-study visit*
 - iii. *ACGME Annual Survey of Residents*
 - iv. *ACGME Annual Survey of Core Faculty*
 2. *Annual Institutional Review (AIR) Action Plans*
 3. *DIOs Annual Executive Summary of AIR to governing body –*
 4. *Program Evaluation Committee & Written Annual Program Evaluation (resident performance (milestones), faculty development, program quality including confidential resident and faculty program evaluations, graduate performance including ABFM performance & graduate survey, resident attrition, annual action plans, progress report on previous years action plans)*

- C. *Institutional GME Policies & Procedures*
- D. *Annual Recommendations Re: Stipends and Benefits*
- E. *Major Changes in program structure*
- F. *Response to Clinical Learning Environment Review (CLER) reports*
- G. *Change in participating sites*
- H. *Changes in faculty / PD*

ADJOURNMENT

Event reports and specific patient care related issues are addressed in Executive Session.

GRIEVANCES AND COMPLAINTS:

There may be experiences during the residency when the resident is placed in difficult positions that may, or may not, be related to any action on his/her part. Often such issues can be resolved by talking them through with the involved parties with or without a neutral third person. But sometimes they cannot. The program is committed to being supportive and fair in its response to problems and utilizes its recommendations and the hospital's Human Resources Department and its official Policies as needed to reconcile the problem. We recommend the following first steps:

- First, discuss with the Chief Resident.
- Decide with him/her how to proceed.
- Check our Grievance Policy -
- If in doubt, contact the Residency Director, Duane Bland, M.D.
- Where not to air grievances:
 - Nurses in public areas
 - Medical students in public areas
 - Hospital's Medical Director or Administration, even if the problem seems to be their responsibility.
 - Patients, especially in public areas
- If you believe a significant issue exists that impacts the safety and quality of patient care, a written report should be made so that the appropriate analysis and corrections are made by the relevant clinical supervisors (e.g. nursing, radiology, lab, OR, etc.) See section on Incident Reports.

INTERN ORIENTATION CHECKLIST (In-Patient)

Physician: _____'s Senior Orientation Checklist (Revised June 2017)

Overview

Hospital Tour: badge access, RDU, Cardiac Tele, CCU, L&D, IMCU, ICU, OR, PASS, PACU, 2 Central, 2 East, 2 South, 1 East, Oncology, Pediatrics, ED, Radiology, IR, Lab, conference rooms, lounge/sleep rooms, cafeteria, patio, library, shortcuts

Programs Access: Cerner (all accounts), remote Cerner (Citrix), WatchChild, AirStrip OB, PACS, signout lists

Cerner: downtime procedures, powerplans/orders/verbal orders, powernotes/notes/addendums/dictations, labs/imaging, messages, patient lists/personal lists/tracking board, templates/macros/.phrases

Documentation: note requirements (content/timeliness), co-signatures, D/C summary responsibility, working/final Dx

Rounds and Daily Work: pre-rounding, data harvesting/organizing, rounds, admissions, appropriate census numbers, sign-out list details/updates, timely orders/consults, timely note completion, anticipate note addendums, telephone encounters, learn/personalize/demonstrate efficient workflow routine, departs/transfers, things commonly overlooked/forgotten/delayed

Transitions of Care: orientation to rotation/team, set expectations, sign-out readiness/thoroughness, trust your peers

Admissions: ensure EDIP, timely throughout, patient placement order via attending phone/verbal order, inpatient/observation, diet/IVF/pain/prophylaxis considerations, insulin/hypoglycemia protocols, appropriate floor, dispo/discharge planning, med reconciliation, code status (AD/POLST)

Consults: Physician Specialists (daily ED call list), PT, OT, RT, Speech Therapy, Nutrition Therapy, Social Services, Spiritual Care, Palliative Care, Hospice, Case Management, Rapid Response Nurse

Communication: staff, phone/text/pager, senior resident/attending, new admits, change in status, closed-loop, HIPAA texting

Codes: expectations, refer to BLS/ACLS/PALS/NRP/ALSO training, team development

Quality Measures: stroke, ACS, PNA, influenza, sentinel events, against medical advice (AMA), medical staff rules and regs

References: Resident Survival Manual, Policy Medical, UpToDate, Textbooks (library, peds desk, OB desk), smartphone apps/links (Epocrates, Medscape, UpToDate, OB Wheel, ASCCP, BiliTool, ASCVD, GBS, AHRQ ePSS, ABFM Exam Prep, AirStrip OB, etc...)

Overwhelmed: senior resident, short call, jeopardy, consult, rapid response RN/MD, attending, ED physician, intensivist

Learning: read daily, morning report, ITE and licensing/board exams, journals, noon lectures

Residency Curriculum Resource: <https://www.fammedrcr.com/>

Derm lectures: <https://www.aad.org/education/basic-dermatology-curriculum>

Physician: _____'s Intern Orientation Checklist (Revised June 2017)

Medicine-Family Practice

Rotation 1

Rotation 2

Common Cases:

- | | |
|-----------------------------|-------------------------------|
| 1. Acute coronary syndrome | 11. A-fib with RVR |
| 2. TIA/CVA | 12. Sepsis/Metabolic Acidosis |
| 3. Pneumonia | 13. Delirium |
| 4. COPD | 14. Syncope |
| 5. CHF | 15. Hyponatremia/Hyernatremia |
| 6. Pancreatitis | 16. Hypokalemia/Hyperkalemia |
| 7. EtOH Withdrawal Protocol | 17. Urinary retention |
| 8. AKI/CKD | 18. Constipation/SBO |
| 9. Upper GI bleed | 19. Edema |
| 10. Anemia | 20. Cellulitis |

OB-Gyn

Rotation 1

Rotation 2

Common Cases:

- | | |
|--|---|
| 1. Normal labor and delivery (scrubbing in, sterile technique) | 11. Non-stress test |
| 2. Preterm labor | 12. UTI/Pyelonephritis in pregnancy |
| 3. PPROM | 13. Abnormal uterine bleeding |
| 4. PROM | 14. Ovarian torsion/cyst |
| 5. Ectopic pregnancy | 15. <u>Tubo</u> -ovarian abscess |
| 6. IUGR | 16. Pregnancy dating |
| 7. Dystocia | 17. Induction of labor (plus IUPC, FSE, AROM) |
| 8. Postpartum hemorrhage | 18. Intrauterine fetal demise |
| 9. Pre-eclampsia/Pregnancy induced hypertension | 19. Perineal repair |
| 10. Gestational Diabetes | 20. GBS prophylaxis |

Pediatrics

Rotation 1

Rotation 2

Common Cases:

- | | |
|---|--|
| 1. Normal newborn exam | 11. Cellulitis/cervical adenitis/ <u>peritonsillar</u> abscess |
| 2. Newborn discharge spiel | 12. Non-accidental trauma (SCAN protocol) |
| 3. Hyperbilirubinemia | 13. Neonatal abstinence syndrome |
| 4. Neonatal fever/EOS Calculator (Kaiser) | 14. Cardiac murmur |
| 5. Indications for LP | 15. Neonatal hypoglycemia protocol |
| 6. Bronchiolitis | 16. Kawasaki Disease |
| 7. Asthma | 17. Dehydration/Acute gastroenteritis |
| 8. Pneumonia | 18. Failure to thrive |
| 9. Pyelonephritis | 19. BRUE/Febrile seizure |
| 10. Appendicitis | 20. Diabetic ketoacidosis |

IN-TRAINING EXAMINATION

The In-Training Exam (ITE) developed by the American Board of Family Medicine and administered by all residency programs in November provides one of many gauges of resident training and progress. Our program uses as a passing score above or equal to 20 percentile (calculated based on statistical data provided by the ABFM) Composite Score for the Post-Graduate Year. Given that the ITE simulates the board exam, the program takes specific action for residents who score below 20th percentile including the following:

- No moonlighting privileges for that resident*
- Resident meets with academic advisor and develops written plan for study and retesting
- Academic Advisor meets with resident on a regular basis to monitor progress
- Resident takes ITE (retest) and academic advisor makes recommendations to program director based on results
- Program director considers reinstating moonlighting privileges

*Exception: In consultation with academic advisor, the program director may consider continuation of moonlighting under the following circumstances:

- Composite Score of >20th percentile for National Total Percentile
- Good performance on residency clinical rotations
- Moonlighting occurs at a site that has a residency faculty member (community preceptors or core faculty) who has been informed by the resident of plans for study and retest due to a low score on the ITE

LEAVE POLICIES:

Refer to Human Resources Policies and Procedures

LEAVING THE HOSPITAL AGAINST MEDICAL ADVICE (AMA):

Should a patient insist upon leaving the hospital without approval of the attending physician, the hospital has absolutely no right to detain him, unless he is a minor or under legal commitment. The hospital must avoid, as far as possible, permitting the patient to jeopardize his safety and must protect itself from possible slander and lawsuits. The following procedure must be carried out, and this is the responsibility of the CHARGE NURSE ON THE FLOOR on which the patient is staying:

- Notify the attending physician of the patient's intention.
- Warn the patient of the possible risk incurred in his leaving against medical advice.
- Request the patient to sign "Release from Responsibility, Leaving the Hospital against Doctor's Advice" form.
- If the patient refuses to sign, be sure to make a notation in the chart, and have at least one witness to the patient's verbal refusal to sign.
- Complete a Notification Form.

LEGAL ISSUES

Legal Procedure for court summons for cases involving residents

1. Resident signs and dates when the summons is received
2. Deliver the summons to the Residency office as soon as possible.
3. Coordinator copies and submits the summons to Risk Management and they will process the paperwork with Legal Department and advise you of the follow up needed.

LICENSURE:

MMCR will pay for the initial California License for residents at the completion of PGY I for US Graduates and at the completion of PGY II for International Medical Graduates. Residents are expected to submit an application for licensure 2 weeks after completion of these years (they are expected to take USMLE 3 or COMLEX 3 and have results by this time). If the application is submitted late, reimbursement will be based on the following schedule:

- | | |
|-------------------------------|--------------------|
| • 0-2 weeks after eligibility | 100% Reimbursement |
| • 2-4 weeks after eligibility | 75% (reduced 25%) |
| • 4-6 weeks after eligibility | 50% (reduced 50%) |
| • 6-8 weeks after eligibility | 25% (reduced 75%) |
| • More than 10 weeks | no reimbursement. |

If license renewal is required during residency training, the reimbursement will be prorated to reflect the time left in the program. Each family practice resident is responsible for scheduling and completing the USMLE or COMLEX in a timely fashion in order to send a completed application at the expected time. This means taking the exam mid-year. **Time off for the exam is considered residency time (not PTO), but it MUST be scheduled in advance through the residency office so that the call, service, and FPC schedules can be adjusted.** The residency office will provide residents with application packets from the California Board of Medical Examiners, but it is the full responsibility of each resident to process his/her application and deal directly with the California Board for any questions about Board policy and procedures.

After licensure, residents must apply to the US Drug Enforcement Agency for controlled drug prescribing privileges (DEA license). After obtaining a DEA number, the resident can obtain controlled substance prescription pads in order to write for Class II-IV drugs. Please see the Residency Office for application information.

MAIL AND MESSAGES:

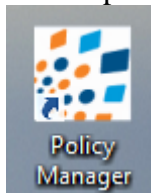
Mailboxes at Mercy Medical Center, Mercy Family Health Center, email and e-mail should be checked frequently, and action taken expeditiously when needed. Residents are provided with pagers accessed via Mercy Medical Center Switchboard. Notify the MMC operator if your pager seems to be malfunctioning. Please attempt to keep your pager from dropping into puddles, toilets, or rivers and please safeguard it from loss or theft.

MALPRACTICE:

The program provides ongoing malpractice insurance to all residents. If you encounter any situation that you think might involve legal action, notify the Program Director at once. This includes receiving legal documents asking for patient records; a bad clinical outcome, which could in any way be construed to involve negligence or other malpractice; or threats of suit from an angry patient or family member. The hospital also provides a “Tail” coverage, which means you are covered for events that occur while you are a resident even after you leave the program. If after graduation you are ever named in a law suit involving a patient at Mercy, contact the Residency Program immediately so that we may involve our Risk Management and assist you as appropriate. NEVER “GO IT ALONE.”

MEDICAL RECORDS:

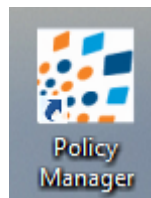
Hospital and Medical Staff Policies can be found on all hospital computers under the Policy Manager icon and/or the Medical Staff Service Department.



Completion of medical records is important for multiple reasons including communication of patient care between providers, patient safety, billing, and regulatory requirements. The medical staff rules regarding timely completion of charts apply to residents, even though they are not official members of the medical staff and do not have admitting privileges; residents work under the privileges of the attending. Residents placed on “suspension” for incomplete medical records must remedy this within 24 hours. If records are not completed, the resident will be pulled from their rotation. If the suspended resident is on an in-patient service, another resident on an elective or other available rotation will be pulled to cover. This resident will be paid back. If the “suspended” resident is scheduled for call, the Jeopardy resident will replace them. This resident will be paid back. A copy of medical records suspension will be added to the resident file for reference. A residence who has been on 90 days of suspension will be suspended from the residency program for 10 days resulting in delayed graduation and documentation in the resident file.

MEDICAL STAFF BYLAWS / RULES AND REGULATIONS OF THE MEDICAL STAFF

Hospital and Medical Staff Policies can be found on all hospital computers under the Policy Manager icon and/or the Medical Staff Service Department.



MEDICAL STUDENTS:

Policy and Procedures for medical students rotating at Mercy Medical Center Redding are coordinated through the residency office and distributed to the health center and hospital rotations when students are present. We only take senior students, or third year students, from LCME or AOA approved schools who have completed core rotations.

MEDICAL STUDENTS APPLYING TO RESIDENCY–CRITERIA

The following information is provided to medical students applying to our residency program and includes criteria for interviewing. (Changes may be made for the upcoming interview season.)

Thank you for your interest in the Mercy Redding Family Practice Residency Program. Our ACGME accredited residency program is located in Redding, California. We are sponsored by Mercy Medical Center, a member of Dignity Health, and affiliated with the University of California, Davis. It is our goal to train high-quality family

physicians to meet the health care needs of California, to practice with medically underserved populations, and to be leaders in our medical communities.

We are a member of the UC Davis Network of Family Medicine Residency Programs. These programs include seven separate programs: Mercy Medical Center, Redding; Mercy Medical Center, Merced; Doctors Medical Center, Modesto; Shasta Community Health Center, Redding; University of California, Davis Medical Center, Sacramento; San Joaquin General Hospital, Stockton; and David Grant USAF Medical Center, Travis AFB. The Mercy Redding Family Practice Residency Program works closely with Redding's Shasta Community Health Center Family Medicine Residency Program sharing resources and working together on inpatient and outpatient clinical rotations. To make it more convenient for our applicants, we coordinate our own interview days and encourage you to apply to both programs.

Intern Positions: In order to ensure the best interview date, please submit all application materials no later than December 1, 2017. We only accept applications through ERAS. You need to submit an ERAS application to each program you are interested in.

International Medical Graduates: Applicants must have a current ECFMG certificate and a Post Graduate Training Authorization Letter (PTAL) from the Medical Board of California by rank day to be considered for the match. Keep in mind that it can take up to 100 days for the California Medical Board to process your documents once they have all been submitted. Due to this processing time, we will not consider interviewing international graduates who graduate after December 1, 2017. Applicants must also provide a receipt of application from the Medical Board of California before we will consider interviews. If you are an international medical graduate with more than 36 months of post graduate training in the USA (24 months for US Medical Graduates), you must have a California Medical License before starting residency training in California. For further information, visit the website for the Medical Board of California <http://www.mbc.ca.gov>.

Frequently asked questions

1. What are your minimum score requirements?

There are no minimum score requirements, but scores may be used to prioritize invitations to interview. Applicants with more than one examination failure on the USMLE or COMLEX may be excluded from the applicant pool.

2. Do you accept IMGs in your program?

Yes, we accept IMGs.

3. Are there IMGs working in your program?

Yes.

4. Is US experience mandatory for the program?

Yes, US experience including hands-on patient care, writing notes, developing treatment plans, and writing orders is required in hospital based and outpatient settings. Observation alone does not meet these criteria. Experience in family practice or another primary care field is encouraged. Applicants must have recent letter of reference from a physician supervisor in the U.S. documenting clinical performance and level of care. These references should include documentation of experience in hands-on patient care and responsibility for writing notes, developing treatment plans, and writing orders. Applications without clear documentation of these experiences will not be accepted.

5. Does the program sponsor Visas?

No. The program only accepts J1 Visas.

6. Does your program accept DOs?

Yes, our program has a long tradition of accepting and training osteopathic physicians. In addition, we have core and community osteopathic faculty members.

7. Are both the USMLE and COMLEX needed for DO students?

No. One or the other is acceptable.

8. Where can I get a listing of where your residents attended medical school?

Please take a look at our website for information pertaining to our current residents and graduates.

9. When does your program conduct interviews?

The interview season runs from October through January. Please take a look at our website for the most current information.

10. How many years after graduation from medical school do you still consider applicants for an interview?

For the 2018 incoming class, applicants must have graduated from medical school during or after 2015. For applicants who have not graduated in the past year, significant clinical experience since graduation must be documented along with written letters of reference. Applicants must have recent (the past year) US clinical experience to be considered for an interview.

11. Does your program offer observerships?

No, all students who participate in rotations at our program must be currently enrolled in LCME or AOA accredited schools.

I suggest taking a look at the following websites to get detailed information on our residency programs:

Mercy Redding FP Residency:

<http://www.ucdmc.ucdavis.edu/fpnetwork/redding/>

Shasta Community Health Center FM Residency:

<http://www.shastahealth.org/schc-family-medicine-residency-center>

UCDavis Family Medicine Residency Network:

<http://www.ucdmc.ucdavis.edu/fpnetwork/index.html>

If you have any additional questions, please contact me. Thank you again for your interest in our program.

Residency Coordinator

Mercy Redding Family Practice Residency Program

MERCY MEDICAL CENTER PERSONNEL POLICIES:

For general personnel policies and procedures, please refer to Mercy Medical Center Redding North State Service Area Human Resources Policy Manual. Copies of this manual may be located in the Human Resources Department or by signing into a hospital computer using single sign-on and selecting the Everyday Use MMR Icon.

For any injury on the job, employees should be seen at Employee Health (6193) during the day or at the Emergency Room (7200) during off-hours. You must report even minor injuries that are incurred while working for Mercy Medical Center as such injuries (which may incur considerable expense and loss of work) are covered by Workman's Comp, not by your regular

health insurance! Failure to report can have significant negative consequences for you personally.

MOONLIGHTING POLICY:

Outside employment must be approved by the Residency Program Director and this approval is subject to the conditions outlined below:

1. Moonlighting is a privilege permitted only to the extent that it does not interfere with a resident's performance in the program, complies with the ACGME guidelines on Duty Hours including the 80 hour work limit, and has the Program Director's approval taking into account the resident's performance in the program and readiness to assume the responsibilities of the moonlighting experience.
2. Every resident must complete the intention to moonlight form available from the residency office prior to starting moonlighting. A separate form must be completed for each employer.
3. PGY1 Residents are not allowed to moonlight. Licensed PGY2 and PGY3 residents in good standing may be granted moonlighting privileges; these are effective through the remainder of residency unless evidence of inadequate academic progress becomes apparent.
4. Clinical services rendered while moonlighting are NOT covered by the residency liability-malpractice policies. Residents must not undertake any outside physician employment unless professional liability coverage is obtained. Residents may obtain personal malpractice coverage or arrange for this to be covered by the external employer. Moonlighting agreements should clearly document liability coverage provided. Evidence of coverage must be provided to the program director upon request.
5. Residents must document the number of moonlighting hours worked and submit to the residency office. While on rotation, we recommend limiting moonlighting to a maximum of one time per week and one time per weekend. Moonlighting on post-call days is not permitted. No moonlighting is permitted during residency duty hours at any time including daytime rotations or on-call periods. In addition, moonlighting must not affect availability while on jeopardy call.
6. If moonlighting activities detract from the residency experience, then the program director may revoke moonlighting privileges. Issues that may affect moonlighting privilege include excessive fatigue, not being available to family practice obstetrical patients, excessively delinquent medical charting, and poor performance on the In-Training Assessment Exam as defined by <20% for Post-Graduate Year.
7. Potential consequences of not following the moonlighting policies include: 1) No moonlighting permitted 2) Recommendation of remedial rotations, substitution of core for elective rotations, or a delayed graduation date. 3) Failure to be certified as board eligible by successful completion of the entire prescribed curriculum.
8. Approval for moonlighting is subject of revocation at any time. Approval for moonlighting does not constitute an endorsement or recommendations of the outside employer.

OTHER RESIDENT/EMPLOYEE BENEFITS:

- Employee Assistance Program: Confidential professional counseling and referral service for you and your family
- Parking: Residents should obtain pass cards from the Medical Staff Office for entering the Doctor's Parking Lot.
- Meals: Food will be free from the Mercy Medical Center cafeteria for residents on duty.
- Sleep Room: A room with telephone in the hospital will be provided for residents on night and weekend call.
- Immunizations: Residents may receive immunizations for rubella, hepatitis B, and diphtheria-tetanus via Mercy Medical Center Employee Health. The program encourages staff members to be fully protected against these potential occupational hazards.
- Book Allowance: Dependent on funding from UC Davis, a book allowance for up to \$200 per year may be used to purchase medical texts, journals, computer software or other educational items as approved by the program director. Residents should purchase books and return original receipts to the residency office by January 15th.
- Pager: The program will provide use of one pager plus one replacement pager for loss or breakage that occurs during residency training. The resident will be financially responsible for the cost if more than one replacement pager is needed.
- Membership on the AAFP for all three years.
- Cost of California medical license while in our residency (in order to qualify, license must be submitted by July 15th of PGY2 or 2 weeks after eligibility). If license renewal is required during residency training, the reimbursement will be prorated to reflect the time left in the program.
- Cost of DEA certificates while in our residency
- Expense Reimbursement: Residents may be reimbursed for certain expense such as mileage for the rural rotations and expenses for attending approved meetings or residency fairs. In order to be reimbursed for expenses, residents must provide the residency office with original receipts and documentation of the expenses within 30 days of when the expense is incurred. If the resident is attending a residency fair, conference or meeting at the request of the program, the resident must complete a "Request for Permission to Attend Workshop, Seminar, Institute, Etc." form. This form must be approved by the Program Director prior to the event.
- Advance payments for travel expenses: In certain cases the Residency Office can obtain advance payments for expenses incurred on behalf of the residency. In order to obtain an advance, the resident must provide an approved "Request For Permission to Attend Workshop, Seminar, Institute, Etc." form and other requested documentation to the Residency Coordinator at least 2 weeks before the money is needed. The resident must also specifically request an advance payment of expenses, as one will not automatically be given.

PAID TIME OFF (PTO):

There are several policies to consider when taking PTO. These include the Mercy Medical center Paid Time Off (PTO) policy and the policies for absence from a residency program as

defined by the American Board of Family Medicine (ABFM). Policies relating to leave may be modified to meet requirements and policies of the American Board of Family Medicine and the American College of Graduate Medical Education. The Mercy Redding Family Practice Residency Program provides the maximum allowable vacation/leave allowed by the ABFM without extending residency training. Scheduled PTO includes up to 4 weeks vacation and up to 2 additional Personal days (see below). Per Mercy Medical Center policies, another 3 days of PTO is available for short term sick leave, but using this time will result in extension of residency training. Depending upon individual circumstances and PTO hours already used, PTO for illnesses may be taken from the scheduled vacation and personal days to prevent extension of residency training. However, PTO and vacation times cannot be applied to other academic years for this purpose. PTO hours must be used in the post graduate academic year in which it is provided. Residents will be paid for unused PTO at the end of the contracted year. Following 3 days of a particular illness, long term sick leave hours may be used. Mercy Medical Center recognized holidays do not require special accounting and do not detract from PTO hours unless this occurs during scheduled vacation. A bank of long term sick leave begins to accrue at the beginning of employment with Mercy. For additional PTO, short term sick leave, and long term sick leave policies (i.e. pregnancy), the Mercy Medical center human resources department and/or the residency office should be consulted.

PERSONAL DAYS

Residents have two Personal Days (mental health days) each year - only one day is allowed during a given rotation. These days are to be scheduled at your discretion, but personal days cannot be used to extend vacation time or holidays and service coverage must be maintained. The Program Director, the health center, co-resident(s), the chief resident and your service attending must be notified if you are taking a personal day. It is acceptable for these days to be used for personal reasons (religious holiday, birthday, anniversary, etc.). Hospital call and scheduled health center clinic time must be covered. Policies relating to leave may be modified to meet requirements and policies of the American Board of Family Medicine and the American College of Graduate Medical Education.

Once a year, however, residents may make one unscheduled clinic change with at least 10 working days' notice so staff can contact patients prior to their appointments. One-time clinic changes may be done for personal time off (PTO), or work reasons: CME, interviewing for a future job, or elective rotation time. Additionally, the change must be approved by the clinic manager (Sharon Babcock) to make sure that it will not affect clinic staffing. The residency office has the appropriate paperwork. We ask that you begin the paperwork as soon as possible to make these days as smooth as possible for all concerned.

PRESCRIPTIONS:

Hospital Discharge: A licensed resident preferably writes discharge orders and prescriptions, using his/her name and license number. If an unlicensed resident writes discharge prescriptions, then the attending physician must sign the prescription and the attending physician's name and

number are used. The resident must indicate on the discharge order the name of the attending and the date of discharge as this is used both for medications and a variety of other health care agencies (e.g. “Discharge from the Service of Dr. <attending>. Follow-up with Dr. <attending> or with <clinic>”)

The following items will apply to prescriptions for controlled substances:

- Schedule II drugs:
 - These drugs must be written using a controlled substance prescription pad and signed by the physician specific for that prescription pad, whether it is an attending or licensed resident with a DEA number.
 - Schedule II drugs may be written for terminal patients using standard prescription pads if the physician writes on the prescription “11159.2 Exemption”
- Schedule III and IV drugs:
 - These drugs may be written by a licensed resident or attending physician using his/her DEA number and the controlled substance prescription pad specific for that physician. Alternatively, a schedule III or IV prescription may be written using a standard prescription if it is faxed or called into the retail pharmacy by telephone, using the prescriber’s DEA number.
- Residents must be licensed and have a DEA number to write for controlled substances.

Outpatient: When unlicensed residents write outpatient prescriptions, the prescription must be co-signed by the preceptor. Licensed residents do not need co-signatures. Prescriptions for controlled substances can only be written and signed by a licensed physician possessing a DEA certificate. Schedule II prescriptions require use of security prescriptions.

Helpful Hints to reduce medication errors:

Include patients name and date of birth on all prescriptions

Create a clear, consistent and standard way for you to write every prescription. For in-patients, this could be: Drug, Strength, Form, Route, Frequency, Duration. Example: Amoxicillin 250mg/tab, One tab p.o. q6h X 7days.

An out-patient prescription should also indicate the number to dispense and refills. Example: Amoxicillin 250 mg tabs. Disp #28. Sig: One tab po q6h X 7 days. No Refill.

Refrain from using abbreviations such as:

“u” for units, “iu” for international units

“pen” for penicillin,

“QD” for daily, “QID” for 4 times daily, “QOD” for every other day,

“MS” for Morphine Sulfate, “MSO4” for Magnesium Sulfate,

or apothecary symbols for drams, minims, or ounces. These words should be written out instead.

Write “ml” not “cc”

Eliminate the use of “trailing zero’s” – use 2mg instead of 2.0mg (easily mistaken for 20mg). Always use “leading zero’s” – use 0.125 rather than .125.

Order medications by “mcg,” “mg,” or “g” strength when possible. Example: Tylenol 650 mg instead of Tylenol 2 tabs (Tylenol comes in different strengths).

Be aware of potential look-alike and sound-alike drugs

Do not write “Resume previous orders.”

When in house, write the order, don't make it a verbal order to the nurse on the floor. Avoid giving phone orders whenever possible.
 Print your name for each order, with beeper #. Write clearly!!!

PROCEDURE COMPETENCY

The program uses a method by which all procedures will be supervised and evaluated and kept in an online database called New Innovations. The program has devised a credentialing process to establish whether or not a resident is competent to perform specific procedures. Residents will document their procedural experience, including the name of the procedure, age and gender of patient. The supervising physician will document the level of performance (e.g., progressing toward independent performance). Procedural teaching includes didactic presentations, indications and contra-indications, risks and benefits, informed consent, appropriate coding and charging, sterile technique, management of aftercare and complications, sterile technique, and acquisition and maintenance of skills. The academic advisor will review their assigned residents' procedure log bi-annually and discuss the progress of their training.

The following includes the procedural competencies for each area of residency training along with the number of procedures required prior to completion of the residency program. Also listed is the number of procedures required before independent status is granted.

Preceptors will use New Innovations to document the supervision of each procedure and to rate the level of resident performance using the following code: **1**= required significant assistance; **2**= required minimal assistance; **3**= procedure performed satisfactorily without assistance. Resident must perform the minimum number of procedures as outlined below and demonstrate level 3 performance on at least 2 occasions to be considered competent.

After a resident demonstrates proficiency, a preceptor will still need to observe future cases during the key part according to MediCare supervision guidelines for billing purposes.

For more information about Procedure Requirements at MFHC, go to this section of the Resident Handbook found under the heading **ADDENDUM - MFHC CLINIC MANUAL**

EMERGENCY MEDICINE PROCEDURE LIST

PROCEDURES	MINIMUM NUMBER TO GRADUATE	MINIMUM NUMBER FOR COMPETENCY
Laceration Repair- Skin	5	5
Laceration Repair- Tendon	0	5
Anterior Nasal Packing	0	5
Foreign Body Removal- Eye	0	2
Foreign Body Removal- Nose	0	2
Foreign Body Removal- Ear	0	2
Lumbar Puncture- Adult	0	5
Lumbar Puncture- Child	0	5
Thoracentesis	0	5

Paracentesis	0	5
Chest Tube	0	10
Central Line Placement	0	25
Dislocation Reduction Shoulder	0	5
Intubation	0	15
Resuscitation-Cardiac (ACLS)	Obtain ACLS certification	Per AHA guidelines
BLS	Obtain BLS certification	Per AHA guidelines
ATLS	0	0

GYNECOLOGY PROCEDURE LIST

PROCEDURES	MINIMUM NUMBER TO GRADUATE	MINIMUM NUMBER FOR COMPETENCY
Colposcopy	1	20
Cervical biopsy	0	10
Cervical polypectomy	0	2
Cervical Dilatation and Curettage	0	10
Endometrial Biopsy	0	5
IUD Insertion	0	5

MEDICINE PROCEDURE LIST

PROCEDURES	MINIMUM NUMBER TO GRADUATE	MINIMUM NUMBER FOR COMPETENCY
Lumbar Puncture	0	5
Thoracentesis	0	5
Paracentesis	0	5
Endotracheal Intubation	0	15
Arterial Catheter Placement	0	5
Central Venous Line Placement	0	20

MERCY FAMILY HEALTH CENTER OUTPATIENT PROCEDURE LIST

PROCEDURES	MINIMUM NUMBER TO GRADUATE	MINIMUM NUMBER FOR COMPETENCY
Anoscopy	0	1
Slit Lamp Exam	0	5
Nail Removal	0	4
Excision of Lesion	5	5
Laceration Repair	5	5
Suture Removal	1	1
Shave Biopsy	3	3
Curettage & Desiccation	0	3
Punch Biopsy	3	3
Casting Short Arm or Leg	3	5
Posterior Leg or Arm Splint	3	3
Endometrial Biopsy	0	5

I & D/Packing	3	3
Joint Injection/Aspir.	0	5
Cryotherapy	5	5
Trigger Point Injection	0	2
Breast FNA	0	5
Circumcision (using any method)	5	20
Lumbar Puncture	0	5
Colposcopy	0	20

MUSCULOSKELETAL MEDICINE PROCEDURE LIST

PROCEDURES	MINIMUM NUMBER TO GRADUATE	MINIMUM NUMBER FOR COMPETENCY
Joint Injection or Aspiration	0	5
Ganglion Cyst Aspiration	0	2
Digital Block	2	5
Casting Short Arm or Leg	3	5
Leg or Arm Splint	3	3
Trigger Point Injection	0	2
Cast Removal	0	2
Dislocation reduction digit	0	2
Dislocation reduction shoulder	0	5
Hematoma block	0	2

OBSTETRICAL PROCEDURE LIST

PROCEDURES	MINIMUM NUMBER TO GRADUATE	MINIMUM NUMBER FOR COMPETENCY
Delivery vertex (NSVD)	25	25
Episiotomy and/or repair of perineal lacerations	5	5
Repair of perineal lacerations 3 rd degree	2	10
Repair of perineal lacerations 4 th degree	0	5
First Assist Caesarean Section	5	5
Vacuum extraction	0	5
Dilation and Curettage	2	10
ALSO Course	0	0

PEDIATRIC PROCEDURE LIST

PROCEDURES	MINIMUM NUMBER TO GRADUATE	MINIMUM NUMBER FOR COMPETENCY
Neonatal Intubation	0	20
Circumcision Gomco*	5	20 (using either method)

Circumcision Plastibell*	0	20 (using either method)
Lumbar Puncture	0	5
PALS and NRP	Maintain Certification	Per AHA guidelines

SURGERY PROCEDURE LIST

PROCEDURES	MINIMUM NUMBER TO GRADUATE	MINIMUM NUMBER FOR COMPETENCY
Surgical First Assist	10	10
Breast FNA	0	5
Wound Debridement	2	2
Central Line Placement	0	20

PROFESSIONALISM

ACGME requires that programs provide educational experiences as needed in order for their residents to demonstrate compassionate, appropriate, and effective patient care, Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals; and a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds. Residents will receive training in professionalism through lectures, and longitudinally during each of their clinical rotations. Competency in this area will be assessed during the evaluation process and reviewed during academic counseling. Examples of these areas include:

- Integrity
- Respect for Others
- Altruism
- Communication – appropriate and timely
- Commitment
- Honesty
- Teamwork
- Personal Hygiene/ Dress/ Composure
- Patient Care
- Administrative Tasks
- Rotation Attendance and preparedness
- HIPPA Compliance
- Work Hour Compliance
- Appropriate use of social networking

Medical Staff Expectations for Professional Behavior

Residents are expected to adhere to the professional standards outlined in the medical staff policy Professional Conduct, Prohibition of Behaviors that Undermine a Culture of Safety:

All Medical and Allied Health Professional Staff members shall conduct themselves at all times while on Hospital premises in a courteous, professional, respectful, collegial, and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, Allied Health Professionals (“AHP”), nursing and technical personnel, other caregivers, other Hospital personnel, patients, patients’ family members and friends, visitors, and others. Such conduct is necessary to promote high quality patient care and to maintain a safe work environment. Behaviors that undermine a culture of safety including behavior which can be construed as discriminatory or harassing, as defined below, are prohibited and will not be tolerated.

Definitions of Types of Behaviors that Undermine a Culture of Safety

- A. Behavior that undermines a culture of safety is marked by disrespectful behavior manifested through personal interaction which:
 - 1. Interferes, or tends to interfere with high quality patient care and patient safety or the orderly administration of the Hospital or the Medical Staff; or
 - 2. Creates a hostile work environment; or
 - 3. Is directed at a specific person or persons, would reasonably be expected to cause emotional distress, and serves no constructive purpose in advancing the goals of health care.
- B. “Discrimination” is conduct directed against any individual that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual’s race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation.
- C. “Sexual harassment” is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory or sexual-themed cartoons, drawings or posters). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct interferes with the individual’s employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.
- D. Other Prohibited Harassment includes behavior which creates a hostile or offensive work environment based upon other protected characteristics, included but not limited to, race, sexual orientation, medical condition or age.

Examples of Prohibited Conduct

Examples of prohibited, disruptive conduct may include, but are not limited to, any of the conduct described below if it is found to interfere, or tend to interfere, with patient care or the orderly administration of the Hospital or Medical Staff; or, if it creates a hostile work environment; or, if it is directed at a specific person or persons, causes physical or emotional distress:

- A. **Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient, including, but not limited to, repeated failure to respond to calls or pages;**
- B. Any conduct that would violate Medical Staff and/or Hospital policies relating to discrimination and/or harassment;
- C. Throwing instruments or other objects in a patient care setting;
- D. Yelling or screaming directed at Hospital personnel or others;
- E. Any striking, pushing, or inappropriate touching of Hospital Staff or others.
- F. Use of racial, ethnic, epithetic, or derogatory comments, or profanity, directed at Hospital personnel or others;
- G. Inappropriate comments written in the medical record;
- H. Unauthorized use and/or disclosure of confidential or personal information related to any employee, patient, practitioner, or other person;
- I. Use of physical or verbal threats to Hospital personnel or others;
- J. Intentional filing of false complaints or accusations;
- K. Any form of retaliation against a person who has filed a complaint against a practitioner alleging violation of the above standard of conduct;
- L. Persisting to criticize, or to discuss performance or quality concerns with particular Hospital personnel or others after being asked to direct such comments exclusively through other channels;
- M. Persisting in contacting a Hospital personnel or other person to discuss personal or performance matters after that person or a supervisory person, the Chief Executive Officer (“CEO”), or designee, or Medical Staff leader, has requested that such contacts be discontinued. Medical Staff members are always encouraged, however, to provide comments, suggestions and recommendations relating to hospital employees, services or facilities, where such information is provided through appropriate administrative or supervisory channels.
- N. Obstructing the peer review process by intentionally refusing, without justification, to attend meetings or respond to questions about the practitioner’s conduct or professional practice.
- O. Engaging in outrageous, intimidating or threatening conduct that interferes with an individual’s employment or ability to care out their work obligations, or interferes with the patient care team.

Maintaining Professional Boundaries and Respecting Patients’ Privacy during Patient Examinations

AMA Statement on Professional Boundaries:

The American Medical Association Council of Ethical and Judicial Affairs (1989) addressed

professional boundaries and stated that sexual misconduct violates the trust that a patient places in the physician and is unethical.^[3] This position was further modified in 1991 to add that a sexual or romantic relationship with former patients is unethical if the practitioner uses or exploits trust, knowledge, emotions, or influence that was derived from a previous professional relationship.

Addressing Patients' Perceptions:

Patients may perceive misconduct if proper communication does not occur or if extra measures are not taken to protect their privacy. The California Medical Board has received numerous complaints regarding improper physician conduct that could have been avoided with proper communication and use of safeguards, including the following:

1. Proper explanation ahead of time regarding the scope, nature, or necessity of examinations which included touching private body parts.
2. Allowing adequate private time for the patient to undress and cover properly.
3. Limiting examination to required areas of focus based on patient complaint and insuring adequate covering during the examination.
4. Using appropriate chaperones during examination of private body parts, especially during breast and pelvic examination.
5. Carefully considering language and questions during the interview and examination.
6. Behaviors should not be pursued that would not pass the "colleague disclosure test".

Addressing Sexual Tension:

Erotic undercurrents may occur between patients and physicians and need not end the physician–patient relationship. Although sexual undercurrents are not uncommon in the doctor–patient interaction, sexual behaviors are always inappropriate and may result in disciplinary actions for sexual misconduct. Ways to address sexual tension include:

1. Explaining reasons for sexually related examinations or questions and encouraging patient questions, while maintaining appropriate boundaries.
2. Responding to patients who express erotic feelings in a matter-of-fact manner, emphasizing the doctor–patient relationship, the importance of objectivity, and the physician's desire for it to remain that way.
3. Explaining that rejection of the patient's inappropriate requests or comments does not mean the physician does not care for the patient or does not wish to work with them.
4. If a patient persists with inappropriate requests, or comments, or becomes extremely angry, the physician should respond calmly and with sincere regret that this behavior will cause termination of the relationship.
5. Physicians should seek to understand their personal reactions and attitudes toward sexual issues.
6. Patients who persist in acting out erotic feelings should be transferred to another physician and, pending transfer, sexually related issues should be avoided.
7. The physician should explain the change as related to the persistence of the behavior and the physician's decision that it is in the patient's best interests not to continue.
8. Admitting attraction or other feelings for the patient is discouraged as inappropriate disclosure on the part of the physician.

Key Points

- Boundaries between physician and patient permit the unique intimacy of the physician–patient relationship.
- Sexual contact crosses these boundaries and violates the relationship.
- Erotic feelings are signs of potential boundary crossings.
- Physicians and patient erotic feelings and behaviors can be constructively managed.
- It is highly recommended to consult with a faculty member or trusted colleague when potential boundary issues of any kind are detected, and to practice prevention before problems emerge.

Male providers are required to have a female chaperons present for female breast, pelvic, and rectal examinations.

PSYCHIATRIC TEMPORARY CUSTODY (5150):

Any discussion about a 5150 for an inpatient needs to occur between the patient’s attending physician and the Shasta County Mental Health Department or the Redding Police Department (police have the 5150 privilege).

REPORTABLE CASES:

California law mandates that all health care practitioners make a formal report to the relevant authorities when providing professional care to a person suffering from:

- Injury caused by a firearm or assault or abusive conduct
- Sexual assault/rape
- Child abuse
- Abuse of elders and dependent adults
- An injury or condition resulting from neglect or abuse in a patient transferred from another health facility resulting from neglect or abuse

Additional information or reporting requirements may be found in the **California HealthCare Association Consent Manual**; these are available for review at MFHC, Mercy Ob clinic, Hospital Administration, and from departmental nursing supervisors. Note that simple, standardized forms are available in the family health center (MFHC) and in the hospital (obtained from the nursing staff) for use in fulfilling the written reporting requirements described above. All residents should feel welcome and comfortable obtaining guidance and assistance from a faculty member or attending in any case in which potential reporting requirements exists. Consulting and coordinating in these situations is often indicated in order to ensure that sensitive legal and ethical requirements are fulfilled.

Reportable Diseases and Conditions: (communicable diseases, STDs, Hepatitis, TBC, etc.): Telephone, fax and/or written reporting of certain diseases to the Shasta County Public Health Department are mandated. A reporting form is available in each family health center and in the hospital that delineates the specific reportable diseases and provides a listing of the required reporting modes (e.g. some diseases require immediate telephone reports, other require reports by phone and by mail, etc.).

RESIDENT IMPROVEMENT PLANS AND RESIDENT CONFIDENTIALITY

1. In the event that a junior resident requires additional training and supervision in one or more area, the senior resident(s) supervising the junior resident will be informed by the Program Director or another faculty member. With the intent of promoting better education and patient safety, this briefing will include the aspects of the junior resident's improvement plans as it relates to senior residents function as the supervising resident.
2. In addition, residents may be involved in confidential discussions about other residents' performance when serving in their role as the chief resident, assistant chief resident, or as a member of the promotions committee.

SCHEDULES, CALL, and SIGN-OUT

Any change in your schedule including master schedule (rotations), daily schedule, or call schedule must be reported and/or coordinated with the residency office as soon as possible. Changes in the schedule without approval from the residency office may result in a loss of credit for the rotation. A call hierarchy exists in which junior residents have primary responsibility for coverage of the inpatient services. They are supervised by more senior residents who are responsible for overseeing admissions and care of all patients admitted to the resident services. The attending physician is responsible for supervising all resident care, answering questions, and addressing problems. At least two residents are on call each night or weekend, providing 24 hours resident coverage. It is extremely important that patients are signed out appropriately. Upper level and first residents need to be present at sign-out which occurs weekdays Monday through Friday at 1730. **Patient care and precepting must be completed at the family health center prior to residents returning to the hospital for call.** Morning sign-out occurs at 7:00 a.m. Residents on call Saturday and Sunday are expected at the hospital at 7am to begin rounding on patients prior to checkout at 8:30 a.m. Residents will leave the hospital when their work is completed and they have adequately signed out.

SIGN OUT & COMMUNICATION

(This information can also be found in the Resident Survival Manual)

- General Guidelines-

- Be on time, ready to sign out if you are the outgoing team, and ready to work if you are the incoming team. AM sign out is 7:00 AM every day of the week. PM sign out is 5:30

PM on weekdays, 7:00 PM on weekends and holidays. Notify outgoing team ASAP if you anticipate being late to sign out.

- If you are the senior resident and will be unavailable to the team during all or part of the day, ensure there is another senior for back up and you have signed out to your backup.
- Outgoing residents will help see patients before they leave if their night float or call shift ends on a weekend or holiday.
- It is expected that any new patient for a service received within 30-45 min of sign out will be assigned to the incoming team to be seen. Pre-populate the sign out list with known patient info in these cases. Bonus points for anticipating admits and newborns and getting these patients on a list.
- Be sure you are personally accounting for all inpatient encounters and procedures as instructed by your residency program.

-Medicine/FP-

- Medicine and FP services are managed by separate teams of residents during weekdays and by a single resident team on nights, weekends and holidays. However, there are always separate attendings for these services.
- FP includes any adult or pediatric patient of MFHC faculty and residents as well as adult and pediatric patients of SCHC residents. Resident continuity newborns are also admitted to this service.
- There is no limit to FP service patient load.
- Any other patient should be admitted to the resident Medicine service if capacity allows.
- Sign out location is the resident lounge unless agreed elsewhere.
- FP sign out may happen either face-to-face or over the phone.
- Medicine interns are expected to carry at least 5 patients each, on average, per ACGME requirements.
- Combined census for both services on weekends and holidays should approximate 12-15 patients, or as otherwise directed by senior resident. Individual attendings may further direct patient volumes.
- Each ICU patient is considered 2 patients as far as patient census is concerned.

-Peds/OB-

- Pediatrics and OB services are managed by separate teams of residents during the week and by a single resident team on nights, weekends and holidays.
- The peds service includes any pediatric patients not covered by private pediatricians or residents.
- The OB service includes any OB/GYN patients not covered by private OB/GYN physicians.
- Sign out location is the L&D break room.
- Again, residency pediatric patients and continuity newborns will be covered on the FP service as identified above.

-Short Call-

- If assigned, anticipate being available to help see patients from 7-10 AM, longer if needed.

- Call ahead to resident on preceding shift to get a forecast for whether or not you will be needed. Don't assume you are not needed.
- When short call coverage is utilized, the short call resident can be assigned to round for any service or combination thereof.
- The short call resident is expected to help with rounding and any necessary patient care when needed including calling consults if necessary.
- The short call resident should not be assigned to round on complicated patients that will require close monitoring or care throughout the day.

SIGN OUT LIST ELEMENTS

(This information can also be found in the Resident Survival Manual)

*see individual sign out lists for further guidance

MED/FP/PED

Dr: Your name Code: Keep Code status current! Attending:

Consults: List name (specialty)

Dx: (age) old (sex) p/w (signs/symptoms and duration)

PMHx: fit in the pertinent

IVFluids: Try to keep current, Diet: NPO, ADAT or type of diet ordered

Weight: in kg

Studies: List pertinent xrays, US, CT, MRI, etc.

Labs: CBC and BMET will show up on printed list. Put things that need to be trended here or are abnormal for quick reference.

PMD: List and try to put phone number here if from out of town

SIGN OUT: (date) then list problems by # and give txs for each one.

OB

Dx: (age) yo G(#)P(#) @(#)wks by LMP(or unk) c/w (#) wk US p/w...PNC began #wks.

PNC c/b : List

IVFluids: Put membrane status here-intact, ruptured, duration

Labs: List prenatal panel for mom and utox on admit

Sign Out: (date) PPD or POD #(0-3)time and date of delivery, list if PPH or tears. If peripartum add SVE (3/70/-2)

NEWBORN

Dx: (weight)gm NB(F/M) born via (NSVD/pLTCS) @(time) on (date) to a (age) GxPx @ #wks. PNC began #wks.

PNC c/b: list

IVFluids: put AROM/SROM, duration ruptured,fluid-clear or mec

Studies: List apgars w/pof (tone, color, etc)

Labs: Mom's prenatal panel and utox

Baby's blood type and coombs status

PMD: list doc or clinic to help fill out discharge paperwork

Sign Out:(date) PPD/POD #(0-3) NSVD/pLTCS/rLTCS on (date)

Anything abnormal about exam, breast/bottle feeding,

Admission timing guidelines

The program must have a consistent set of guidelines to ensure the patient's safe transfer of care to the in-patient service and to avoid unnecessary resident conflict over "who is responsible for this patient." The times listed refer to the time the ED notifies the on-call resident of the admission.

All mornings: The on-call resident will manage Admissions from the ED at 6:29am or earlier. From 6:30am on, the admission will be held for the incoming resident at 7 am. Incoming residents may accept patients from earlier than 6:30am if they so choose. If there is an urgent need to see the patient during the 6:30-7:00am interval, then the on-call resident will be responsible. Patient safety always is the major determinant.

Monday through Friday evenings: Admissions from the ED up to 5:00 remain the responsibility of the day team. From 5:00 pm on the admission goes to the appropriate on call resident. If there is an urgent need to see the patient during the 5:00-5:30 interval, then the on-call resident will be responsible. Patient safety always is the major determinant.

For patient safety and efficiency, the upper level resident should always exercise their best judgment when assigning admissions around the change of shift times. That decision may over-rule the above guidelines concerning times and which call accepts the admission (e.g., circumstances may make assigning the Peds call resident a medicine admit at 6:45 am). In the event of a disagreement, the upper level resident's decision is the one that applies. Residents may subsequently discuss the issues with the Chief Residents and/or the Program Director, but after the care is rendered and the crisis is over.

Changes to the written call schedule

All resident parties involved must agree upon changes. The resident originally assigned the call remains ultimately responsible for coverage. All changes must to be reported the residency office. This is the responsibility of the resident originally assigned the call. In the event a resident is unable to take an assigned call day due to an acute illness, a family emergency, etc., that resident is responsible for contacting the chief resident and the residency office. The chief resident will assist them with arranging coverage. Changing call cannot interfere with coverage of previously scheduled hours in the family health center or specialty clinics during the post-call period. If the jeopardy call resident takes call, he/she should immediately notify the resident office and any post call clinics that may be affected. (I.e. MFHC, community preceptors, etc.)

Jeopardy call:

Jeopardy call is scheduled as a separate roster. Residents assigned to jeopardy call must be available by beeper to cover in the event of illness or emergency that prevents the on call resident from working. They should remain available to work on a half-hour notice when

contacted by the chief resident or acting chief. A jeopardy call is defined as any call that a resident is unable to perform within 24 hours of the start of the call regardless of the reason. If the jeopardy call resident takes call, he/she should immediately notify the resident office and any post call clinics that may be affected. (I.e. MFHC, community preceptors, etc.) If a jeopardy resident is unable to do a call and knows this >24 hours from the start of the call, it is that resident's responsibility to find a replacement. A "time for time" trade policy for jeopardy call is in effect. Thus, if the jeopardy call person is called in to do a call, the resident who called in sick will repay the call later in the year. This reimbursement call is to be arranged between the two residents involved. If they can't agree, the chief resident will assign the call in a future call schedule. If the jeopardy call person is unable to perform a jeopardy call (for any reason) it remains the jeopardy call person's responsibility to find a replacement. Extended sick leave is to be dealt with on a case-by-case basis. Call in those instances will generally be redistributed throughout the residency without payback.

MASTER SCHEDULE:

The Master Schedule of rotations for all residents and 13 rotations is extremely complex. The Schedule is put together in the spring and must balance the interests of rotations, service coverage, resident requests, health center coverage, and a logical sequence of certain rotations and responsibilities. This schedule has been developed along a variety of pathways in the past, but the bottom line is the appropriateness of the final product. All stakeholders (rotations, health centers, residents) have input in its development and final version. The residency program director has final authority in approving the Master Schedule.

There are events that occur, unpredictably, that impact the Master Schedule such as illness, pregnancy, and personal problems. For such unavoidable reasons, the Master Schedule will be modified by the Program Director in consultation with the Chief Resident, the health center, and the Residency Coordinator using the appropriate Schedule Change Form. There may be less serious reasons for changing the Master Schedule, which may generate a Schedule Change Form and may be considered. However, most changes are complex and will not be made.

HOLIDAYS:

The Mercy Family Health Center is closed on hospital holidays. Hospital call is treated as a weekend call. Mercy Medical Center observes these holidays:

- New Year's Day (Not New Year's Eve)
- Martin Luther King Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving
- Day after Thanksgiving

- Christmas Day (Not Christmas Eve)

As relates to call, generally the Mercy Medical Center holiday schedule dictates which days are considered holidays.

JURY DUTY

Jury Duty - please refer to Mercy Medical Center Redding North State Service Area Human Resources Policy Manual. You must coordinate with the Residency Office if summoned so that we can arrange appropriate coverage.

VACATIONS

Residents take vacation according to the Master Schedule, which is done by the Program Director and Chief Resident after obtaining residents' requests and while making up the Master in order to balance everyone's request vs. service and FPC staffing needs. Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time.

PGYI and PGYII Vacation time is broken up into two 2-week blocks.

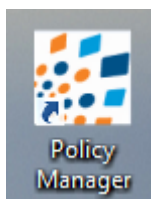
PGY III residents may take one to two week vacation blocks. Vacation cannot be taken during the last two weeks of residency.

Changes to scheduled vacation will only be considered for exceptional circumstances and will usually be denied by the program director. This is a reflection of the difficulty of balancing call, service and FPC coverage. If you do have a request, it must come with a solution to these issues and must be approved by the Chief Resident, the service, and the FPC.

Vacation and PTO time must be used each academic year. Neither can be carried over to the next year. At the end of the academic year, any unused time is "paid out" to you as salary. Any excess use of PTO results in the resident has to extend his/her training time.

SENTINAL EVENTS

Hospital and Medical Staff Policies can be found on all hospital computers under the Policy Manager icon and/or the Medical Staff Service Department.



SICK LEAVE

Residents are responsible to notify the Residency Coordinator if you are unable to work due to illness or if you have a medical/dental appointment. The coordinator will notify your service and health center for coverage as appropriate. A few hours out during a workday is not considered PTO, but you do need to manage the appropriate notifications so your work is covered. After hours and on weekends, the core faculty member on Family Practice Service should be notified in the event of an emergency absence. Sick days are detracted from your PTO pool; please refer to section on Paid Time Off. If the jeopardy call resident takes call, he/she should immediately notify the resident office and any post call clinics that may be affected (i.e. MFHC, community preceptors, etc.). Sick leave is considered time away from residency training by the ABFM. Residents may be required to use scheduled vacation time to make up for missed rotations if it is clear that they will exceed the allowed 30 days per academic year away from residency training. This is only allowed during the same academic year. Hospital PTO will not be used in these circumstances. If all vacation time has already been used, then the residency training and the resident's graduation date will be extended.

SUPERVISION:

Supervision of residents is essential to quality graduate medical education and to the safe care of the patients we serve. Residency is an educational experience that, more than anything else develops judgment and skills and these qualities can only come from responsibility with feedback. Supervision not only involves an assessment of the resident's clinical knowledge and skills, but also interpersonal (professional and patient) skills essential to being an effective doctor.

Supervision (and evaluation) is a requirement of the ACGME, which certifies all graduate medical education programs, and is now re-focusing on competency-based curriculum, which this program has embraced. Each rotation has the defined competencies, which family physicians (and at times family practice residents in this hospital) require to be effective and successful.

Supervision also has regulatory components affecting the supervising physician and his/her obligations as described in Mercy Medical Center Redding's Policy below. All issues of supervision policy are determined at Mercy's Graduate Medical Education Committee, which consists of attending physicians, faculty, and chief resident and administrative representatives (including the Vice President of Medical Affairs).

**POLICY STATEMENT ON GRADUATE MEDICAL EDUCATION PROGRAM
MERCY MEDICAL CENTER REDDING
SUPERVISION OF A RESIDENT**

1. Attending staff physicians who agree to supervise residents do so under privileges granted to the attending by the medical staff. Residents themselves do not have privileges at Mercy Medical Center Redding. Accordingly, in accepting the attending role, a medical staff member agrees to assume responsibility for appropriate supervision of the residents' patient care. Medical staff members have the option of not participating in resident supervision and/or teaching.
2. The attending physician is responsible to round with the resident team everyday he/she is on service. The attending physician is responsible to review the clinical records of all patients on his/her service, checking the work-up and progress notes of the residents. This monitoring should include attention to the resident's ability to structure a differential diagnosis and diagnostic plan, review of therapeutic options and approval of all medications and therapies prescribed by the resident. The attending physician is responsible for signing off on the clinical records including discharge summaries of all patients admitted to their service. The attending physician will complete a brief admission note or authenticate the residents' admission note within 24 hours of admission. H&Ps will be authenticated by a preceptor within 24 hours. For all admissions, the attending will review the resident progress notes daily and authenticate or complete a separate note. Individual orders, including orders for initiation or renewal of patient restraints, are monitored by the attending physician. For billing it is the attending physician's responsibility to follow insurance (i.e. Medicare, Medi-Cal, etc.) requirements for supervision and documentation.
3. Procedure performed by the residents must be supervised in accordance with 1st, 2nd, and 3rd year Description of Duties. Obstetrical faculty is responsible to be present for each resident delivery. It is the responsibility of the delivering resident to notify the attending physician of the impending delivery. For billing it is the attending physicians' responsibility to follow insurance (i.e. Medicare, Medi-Cal, etc.) requirements for supervision and documentation.
4. The attending physician is responsible for notifying the program director of any deviation from appropriate professional standards by the resident. This includes any behavioral issues that affect a resident's ability to perform his/her duties in an effective manner. The program director has the ultimate responsibility to assure that residents meet the standards set in this regard. In cooperation with the faculty, he will determine a course of action to correct the problem and provide supervision with any remedial help required.
5. The attending physician agrees to provide each resident with a written evaluation at the end of each rotation. This may include a formal exit interview at the discretion of the attending. The program director or the resident's faculty advisor will meet with each resident at least two times a year to review these evaluations and address any perceived deficits.
6. If a resident physician is asked to see a private patient on an emergency basis, the care that is provided comes under the supervision of the staff physician responsible for the

patient. Staff physicians should approve the resident's involvement whenever possible and resume direct patient care as soon as circumstances permit.

7. The attending physician is responsible to report unexcused resident absences to the program director. The program director is responsible for assuring that patient care responsibilities are covered.

8. The Program Director will routinely report to the Medical Executive Committee of the Medical Staff, as defined in the Bylaws, and Board of Directors on the quality of care, treatment, and services being provided as well as any educational needs.

Mercy Medical Center Description of Duties for Residents for PGY1, PGY2, and PGY3

This list represents duties of the resident as delineated in the resident job description. Residents are NOT members of the Medical Staff. Their duties and responsibilities are determined by the Accreditation Council for Graduate Medical Education and by the Residency Review Committee in Family Practice. Residents always function in the hospital and clinics under the authority and direction of the attending physician as defined in the hospital policies, (Criteria for advancement are contained elsewhere in the resident manual.)

This list is provided for information to the clinical areas.

Procedural Skills:

All procedures performed by a resident require the direct oversight and presence of the attending physician.

Medical Management and Diagnostic (Cognitive):

1. Performs physical examinations of patients, diagnoses diseases and disorders, and prescribes and administers treatment.
2. Assists in surgical operations.
3. Confers with the attending physician on the examination, care, and treatment of patients, and any substantial change in condition.
4. Confers with relatives of patients concerning condition and treatment.
5. Obtains and records medical histories, physical examinations, and progress notes on all patients examined and treated.
6. Makes rounds of the wards and reports on the condition and progress of patients.
7. Exercises medical judgment in the proper diagnosis, care, and treatment of patients in Mercy Medical Center and the Family Practice Clinic.
8. Makes recommendations to the Director of Family Practice Residency on policy matters.
9. Explains the services available at Mercy Medical Center to members of the general public,
10. Orders and interprets laboratory examinations, analyses, and x-rays.
11. Writes medication orders.
12. Assists in the instruction and supervision of nurses, technicians, and personnel assigned for special training.
13. Attends and participates in clinics and staff conferences on the discussion of surgical, medical, and mental conditions of various patients and their diagnoses and treatment.
14. Prepares case histories, reports, and related correspondence.

Resident Call Expectations and Supervision Responsibilities

PGY1s on weekend call or night float:

- There is always a PGY2 or PGY3 in house to serve as back-up.
- PGY1s must notify the senior resident in-house of all admissions, discharges, or change in patient status (use the same guidelines we have developed for notifying your attending).
- PGY1s must assist with rounding on weekend mornings under the direction of the senior residents (please work with your senior resident to assure that you do not exceed work hour restrictions).

PGY2/PGY3 on weekend call or night float – supervision responsibilities:

- Monitor all resident admits, discharges, or changes in patient status – this allows you to provide education, back-up, and close the service when necessary.
- Obtain a brief check out from the senior resident checking out on the opposite service regarding service status (i.e., green – open and not busy, yellow – open and busy, red – closed) and information on unstable patients and patients that the PGY1 may need assistance with managing.
- Assist PGY1 with patient care if service becomes excessively busy.
- Recommend closure of medicine admissions from the ED if it is anticipated that either the medicine or Ob service has become too busy for both the PGY1 and PGY2/3 to manage together.

Short Call PGY2/PGY3

- Round and supervise/manage PGY1s who are rounding
- Do not leave the hospital until PGY1 coming off call has completed rounding and left

Supervision criteria for senior residents supervising junior residents during low risk labor:

Attending notification guidelines apply to all levels of residency training, PGY1-PGY3. Senior residents will be required to meet specific criteria prior to supervising junior residents during low risk labor. They will have to successfully complete their intern year obtaining the intern certificate and advancement to second year status. They will also need to complete specific OB requirement. They will need to have completion of and continued ALSO (Advanced Life Support in Obstetrics) certification. They must have a minimum of 30 vaginal deliveries documented. OB rotation evaluations must be overall satisfactory and include the “By the end of PGY1- competent to supervise first year residents” performance portion to be satisfactory or above.

When first year residents begin participating in the Night Float Obstetrics / Pediatrics rotation, they must work closely with the senior resident on the Night Float Medicine Rotation. For the purposes of resident education, supervision requirements, and patient safety, the following procedures must be followed:

- **Senior Residents must be notified of all admissions, pending deliveries, or significant change in patient status. Any item that requires attending notification (see below) also requires communication with the senior resident. The PGY1 resident should provide this notification immediately after evaluating the patient – sooner in emergent or urgent situations**
- **The senior resident must be notified of all pending deliveries and is expected to be present for these deliveries**

It is important for both PGY1 and senior residents to follow these procedures. Failure to follow these procedures may result in cessation of the rotation, possible delay in residency advancement, and loss of future elective time while the rotation is made up. It is expected that all residents will continue to follow the usual attending notification guidelines as outlined below:

Attending Notification Guidelines

Attending notification guidelines identify specific criteria that should trigger a phone call by a resident to an attending physician to inform the attending of a change in patient condition. It is expected that the attending will be notified ASAP, following appropriate assessment and stabilization of the patient if necessary, for the following conditions/ circumstances:

1. All Admissions
2. Any significant change in condition
3. Critical labs that may change the course of action of patient care
4. Rapid Response Team call, Code, cardiac or respiratory arrest
5. Unplanned intervention or transfer to higher level of care
6. Iatrogenic event: serious complication from medical intervention
7. Initiation of restraints
8. Discharge AMA
9. Unanticipated death
10. At request of staff member, patient or family member

In Addition for Obstetrics:

1. All imminent deliveries
2. All non-labor patients after evaluation prior to discharge
3. Any significant or unclear FHT or TOCO that may require urgent evaluation and/or treatment
4. Unexpected blood transfusion pre or post-delivery without prior attending knowledge or instruction
5. Fetal demise

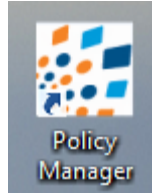
In Addition for Normal Newborns:

1. Any concern or complication
2. Any potential NICU transfer

Note: According to hospital Maternity Service Structure Standards normal newborns must be seen by attending within 18hrs of delivery

VENDOR POLICIES

Mercy Medical Center vendor policies can be found on all hospital computers under the Policy Manager icon:



WORK HOURS

Residency Work Hours are monitored by the residency office. Residency rotation, clinic, conference attendance, and call expectations are structured to meet the work hour restrictions. The chief resident makes the monthly call schedules which are reviewed by the program director to assure compliance. Residents document hours worked using an on-line program - New Innovations. In the event of a work hour violation, the program director explores the circumstance with the goal of preventing further occurrences.

The Mercy Redding Family Practice Residency Program follows The ACGME Approved Standards for residency work hours:

Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.

Mandatory Time Free of Clinical Work and Education

The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.

Residents should have eight hours off between scheduled clinical work and education periods.

There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.

Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Clinical Work and Education Period Length

Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.

Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.

Additional patient care responsibilities must not be assigned to a resident during this time.

Clinical and Educational Work Hour Exceptions

In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

- to continue to provide care to a single severely ill or unstable patient;
- humanistic attention to the needs of a patient or family; or,
- to attend unique educational events.

These additional hours of care or education will be counted toward the 80-hour weekly limit.

Moonlighting

Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety.

Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. PGY-1 residents are not permitted to moonlight.

In-House Night Float

Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

At-Home Call

Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.

At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

IV: ADDENDUM: Mercy Family Health Center Clinic Manual

THE FAMILY PRACTICE CENTER

Mercy Family Health Center is intended to function like a physician group practice within the parameters of educational and supervisory mandates. Residents develop panels of patients for which they are responsible as the Primary physician, and develop strong relationships as well as provide continuous, comprehensive and compassionate care.

Over the three years, residents spend progressively more time in their center, with one or two half-day per week in the first year, two half-days per week in the second year, and three or four half-days per week during the third year. While office hours may vary somewhat according to the resident's rotation, it is essential that the resident sign out from hospital duties in time to be in the center for the first appointment. When a resident is not in clinic, a fellow resident or faculty will care for his/her patients.

Residents are an integral part of the operations at the health center and participate in the clinic meetings designed to review and improve both the clinical and business performance of the centers.

Whenever a resident's patient is admitted to the hospital, he/she is expected to make daily rounds and work with the in-patient team in clinical decision-making and disposition unless the resident is on an away elective, vacation, or in-patient service that precludes such visits. Each upper level resident will have a number of obstetric patients for whom he/she is responsible throughout the pregnancy, labor and delivery.

OFFICE ADMINISTRATIVE STAFF

Clinic Manager:

Administrative Assistant:

Data Coordinator:

Sharon Babcock, RN

Jessica Cardoza-Johanson

Jennifer O'Connor

Medical Director:
Program Director

Steve Namihas, MD
Duane Bland, MD

CORE FACULTY

Duane Bland, M.D., Family Physician, Residency Program Director
John Coe, M.D., Family Physician
Steven Namihas, M.D., Family Physician, Assoc. Program Director
Nena Perry, M.D., Internists/Geriatrician
Jay Roitman, D.O., Family Physician, Medical Director for Employee Health at Mercy Med Center
Clint Evans, D.O., Family Physician
Dan Rubanowitz, Ph.D., Behavioral Science Coordinator
Christine Woroniecki, M.A., Behavioral Science
Sharon Babcock, RN, MFHC Clinic Manager

I. CLINIC SCHEDULE AND TIMES

Over the three years of residency training, residents spend progressively more time in their center, with one or two half-day per week in the first year, two or more half-days per week in the second year, and three or more half-days per week during the third year. While office hours may vary somewhat according to the resident's rotation, it is essential that the resident sign out from hospital duties in time to be in the center for the first appointment. When a resident is not in clinic, a fellow resident or faculty will care for his/her patients.

Residents who are not on vacation or away electives are expected to check their Cerner EHR messages daily and their boxes at MFHC at least twice weekly to complete all prescription refills, review lab results, and attend to any messages from patients, staff, or faculty.

Appointments are scheduled from 7:45 - 11:30 a.m. and 1:30 - 4:30 p.m., although walk-in patients are seen up till 11:15 am. And 4:15 pm for each respective clinic. Residents who have completed all other patient care responsibilities are expected to be available in clinic to see patients up to these times. To assure that all walk-in patients are seen, residents must check with both the preceptor and the desk nurse when leaving the morning clinic before noon or the afternoon clinic before 5 pm. Residents leaving clinic early without checking-out as above will be scheduled for additional clinic time.

Given that processing patients requires 10 to 15 minutes, residents are responsible to be in clinic within 15 minutes after their first patient is scheduled. For those residents on ward rotations, the morning clinic starts at 9:00. Please notify Sharon Babcock, RN, the clinic manager if you are going to be late so arrangements can be made.

Residents will be assigned a maximum number of patients per clinic according to their year of residency training:

PGY1: 3-6

PGY2: 6-8

PGY3: 8-12

Additional patients may be added to the schedule if residents have less than the maximum number of patients scheduled before the start of their clinic. The front office will continue to schedule these “fill-in” appointments until each residents’ schedule reaches the maximum amount indicated above, providing the “fill-in” patient can be seen by the time the fill-in slot is available.

In addition to “fill-in” appointments, residents and faculty are expected to see up to one additional “work-in” patient per clinic to accommodate patients with urgent healthcare needs who would have to be sent to the emergency room. As much as possible, the front office staff will schedule these “work-in” appointments during the beginning of the clinic.

Residents will not be scheduled the day after call. Preceptors are available in the clinic during all times of resident patient care.

GENERAL GUIDELINES

- 1. Confidentiality:** must be maintained by keeping charts face down and keeping discussions about patients confined to the preceptor room.
- 2. Food and drinks:** are not allowed in patient care areas or the preceptor room. Covered beverages will be allowed in the preceptor area.
- 3. Privacy:** Knock before entering into any patient's room in clinic and wait for an appropriate response.
- 4. Sample Medications:** Pharmaceutical Representatives conduct a drug fair in the clinic classroom on Wednesdays from 11 am to 2 pm. Sample medications are no longer kept at MFHC.
- 5. Timeliness:** Residents are expected to attend their clinics regularly and in a timely fashion. If late for any reason, residents must notify the Clinic Manager first, or the Desk Nurse if the Clinic Manager is unavailable.
- 6. The Procedure Log:** Use New Innovations to document all procedures.

II. CLINICAL AREAS

CLIA OUTPATIENT LABORATORY PROFICIENCY TESTING

All providers at MFHC are required to undergo yearly outpatient laboratory proficiency testing according to the Clinical Laboratory Improvement Amendments (CLIA) established by US Department of Health and Human Services. This is accomplished during a noon conference review and test. Review materials are provided ahead of time.

CLINIC I and CLINIC II ROTATIONS

A. Service Goals

The Clinic I and Clinic II Rotations are unique and valuable sets of ambulatory family practice and specialty experiences scheduled at MFHC and SCHC. The general goal is to provide the resident with a hands-on, longitudinal experience in various specialty areas (Allergy, Colposcopy, Dermatology, Family & Community Medicine, and HIV clinic) as defined below under the supervision of the relevant attending. The resident also develops a higher level of involvement and responsibility for the daily operations of the FHC, seeing acute add-on patients, participating in office management, ancillary services, review of patient care studies, and process improvement.

B. Service Description

The Clinic I (C1) rotations occur once in the PGY II and PGY III years. The Clinic II (C2) rotation occurs twice in the PGY II year. (See the Specialty Clinic descriptions under section D). Each month, the C1 & C2 clinic schedule may vary slightly, so the resident must consult the published schedule.

WARFARIN PROTOCOL

All patients having their warfarin anticoagulation therapy managed at MFHC will be enrolled in a management program to assure proper use and monitoring of this medication.

Providers will refer these patients to the nursing staff who will take the following actions:

1. Enter the patient into the Warfarin Log used to track these patients.
2. Give the patient educational material, including Anticoagulation Patient Education and Warfarin – Effects of Foods and Supplements.
3. Have the patient sign the Warfarin Therapy Agreement which addresses the use of warfarin, including risks and benefits and the need to take as directed and perform blood testing as directed.
4. Initiate a Warfarin Flow Sheet which will be added to the patient's chart. The flow sheet will be used to document
 - each PT/INR result
 - date drawn
 - any adjustment made to the warfarin dose
 - time for the next draw
 - patient current phone number
 - patient notification.

The provider will fill the following information on the Warfarin Flow Sheet:

1. Indications for warfarin
2. INR goals for therapy
3. Duration of use
4. Initial warfarin dose
5. Time for next PT/ INR draw

Providers will also give patients a six month standing lab order for Protime (PT/INR) with 3x/week maximum frequency.

Once patients are entered into the Warfarin Log, the nursing staff will track patients on a weekly basis to see which patients are in need of PT/INR.

The data coordinator will send out a quarterly report to providers so they can verify that all of their patients who take warfarin have been entered into the log. Nursing staff will also receive a copy.

PT/INR lab results will be processed as follows:

1. When patients have their PT/INR drawn, nursing staff will put lab results in the patient's chart along with a pink Warfarin Chart Flag.
2. Resident chart will then go to the C1 Clinic doc for review.
3. The C1 Clinic Doc will indicate any warfarin dose adjustments and when the next PT/INR should be drawn.
4. The chart will then go to the Nursing Desk.
5. The Desk Nurse will contact the patient and provide instructions for the patient, and document in the Warfarin Flow Sheet.
6. Faculty patient results will be processed in the same fashion, with faculty covering their own patients and those assigned to other faculty members who are unavailable (according to the "Faculty Covering Labs for Faculty" schedule).
7. All patients residing in a care facility must have a physician signed 'MEDICATION ORDERS/CHANGES' sheet that will be faxed to the facility.

All new warfarin patients will be given an Rx for Vitamin K 5 mg to be filled only as advised by a MFHC physician. The following guidelines may be used for the management of significantly elevated warfarin:

1. For PT/INR 5.0 to 8.9 and no significant bleeding: Omit 1 to 2 doses of warfarin; reduce dose 10 to 20 percent; monitor frequently. Alternately consider Vitamin K: 2.5 mg orally.
2. For PT/INR ≥ 9.0 and no significant bleeding: Hold warfarin therapy; give Vitamin K: 5 mg to 10 mg orally; monitor frequently. Resume at lower dose when INR is therapeutic.
3. Serious bleeding, any INR: Hold warfarin and refer to Emergency Department.

Although warfarin management can be done by phone, patients must be seen for evaluation no less than once every 6 months.

MEDICATION ORDERS/CHANGES For Patients Residing in Care Facilities

Patient Name: _____ Date: _____

Care Facility: _____

MFHC Medical Record Number: _____

New Medication: _____

Dose: _____

Existing Medication: _____

Current dose: _____

Change dose to: _____

Labs needed and next draw date: _____

Physician's signature: _____

Faxed to: _____

Date faxed: _____ Initials: _____

Any questions, please contact us:

Phone (530)225-7800

Fax (530)225-7889

OUTPATIENT ANTICOAGULATION FLOWSHEET

Patient's name: _____ Date of birth: ____/____/____ Medical record #: _____

Indication for anticoagulation (check one): • Atrial fibrillation • Deep vein thrombosis • PE • Mechanical valve • CVA • other

Target International Normalized Ratio (INR)*: • 2.0 to 3.0 • 2.5 to 3.5 • Other: _____

Start date: ____/____/____ Therapy duration: • 3 months • 6 months • 1 year • Indefinite • other: _____

Educational materials and Vitamin K prescription given and contract signed: • Patient

Phone _____

Contact Person Name _____ Phone _____ Facility Name _____ Fax

number _____

Date:	Current warfarin dose:	INR:	Inter-acting	New warfarin dose:	Next INR:	Patient notified	Date Re-Notified:
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			Med:				by:	

MANAGEMENT OF SIGNIFICANTLY ELEVATED INR WITH OR WITHOUT BLEEDING³	
INR 5.0 to 8.9, no significant bleeding:	Omit 1 to 2 doses; reduce dose 10 to 20 percent; monitor frequently. Alternately consider vitamin K 2.5 mg orally.
INR ≥ 9.0, no significant bleeding:	Hold warfarin therapy; give vitamin K 5 mg orally; monitor frequently. Resume at lower dose when INR is therapeutic.
Serious bleeding, any INR:	Hold warfarin; refer patient to the Emergency Department

ANTICOAGULATION PATIENT EDUCATION

Your provider has prescribed an **Anticoagulant Medication**. The name of the medication is:
(*provider to circle the medication prescribed*)

Warfarin (Coumadin): an oral tablet

Enoxaparin (Lovenox): a small injection into the skin

Benefits:

Anticoagulant therapy is used to make your blood “thinner” than normal to treat or prevent complications of a disease. “Thinning” the blood dissolves or prevents clots from forming and blocking blood vessels. This decreases the chance of stroke, heart attack and other problems from blocked vessels including in the lungs, brain and legs.

Risks:

Potential complications and side effects of anticoagulant therapy include:

Bruising of the skin

Irritation at the site of injection (Enoxaparin)

Bleeding from the nose, urinary tract, stomach, or colon. Bleeding may also occur in or around the brain (intracranial). In extreme cases, bleeding can result in death.

Contact the clinic staff or seek emergency care immediately if any of the following occur: severe headache, dizziness, any abnormal bleeding including from the nose, urinary tract, stomach, or rectum.

Your lab values will be monitored frequently while you are on this medication. It is important that the medical staff know what your values are so the medication can be adjusted as needed.

The risk of bleeding can be increased if you are taking certain other medication or herbal products. Make sure that your provider and nurse have a complete list of all the medications and herbal products that you take. **Contact your provider if you begin a new drug or supplement to see if additional testing is necessary.**

See below for some information on drug, food and herbal interactions.

Enoxaparin (Lovenox) : Herb/Nutraceutical: Avoid cat's claw, dong quai, evening primrose, feverfew, garlic, ginger, ginkgo, red clover, horse chestnut, green tea, ginseng (all may increase the risk of bleeding).

Warfarin (Coumadin): Foods high in vitamin K inhibit the anticoagulant effect of warfarin including beef liver, pork liver, green tea, and leafy green vegetables. Do not change dietary habits once stabilized on warfarin therapy. A balanced diet with a consistent intake of vitamin K is essential. Avoid large amounts of alfalfa, asparagus, broccoli, Brussels sprouts, cabbage, cauliflower, green teas, kale, lettuce, spinach, turnip greens, and watercress. It is recommended that the diet contain a **CONSISTENT** vitamin K content of 70-140 mcg/day. Check with healthcare provider before changing diet.

WARFARIN – EFFECTS OF FOODS AND SUPPLEMENTS

What you eat can have an important effect on how much warfarin you need to maintain the proper amount of anticoagulation. You should continue to eat your normal diet. Do not make any major changes such as: starting a weight loss diet, going on an eating binge, begin taking vitamin and mineral supplements, or alter the amount of alcohol you ordinarily drink. If you plan to make a change in your eating or drinking habits, check with your provider first.

Vitamin K can also alter your anticoagulation therapy when taking warfarin. Below is a list of foods high in Vitamin K. **TRY NOT TO CHANGE YOUR USUAL CONSUMPTION OF THE FOLLOWING FOODS:**

Beef liver	Garbanzo beans	Seaweed
Broccoli	Green tea	Soy milk
Brussels sprouts	Egg yolks	Soybeans
Cabbage	Lentils	Soybean oil
Cauliflower	Lettuce	Soy products
Collard greens	Mung beans	Spinach
Turnip greens	Green Peas	Kale

Some herbs, vitamin mineral supplements, and non-prescription medications may also alter anticoagulation and **probably should be avoided**. Below is a list of some of the common ones used. If you are taking these or any other herbs or supplements discuss them with your doctor, dietitian, or pharmacist.

Chamomile	Feverfew	Garlic
Ginseng	Ginger	Ginkgo
Saw palmetto	St. John's wort	Kava
Vitamin E	Chondroitin Sulfate	Turmeric
Cranberry products	Bilberry	Bromelains
Coenzyme Q-10	Dong quai	Danshen
Horse chestnut	Meadowsweet	Willow

WARFARIN THERAPY AGREEMENT

I have been given instructions in the use of warfarin for anticoagulation therapy and have had the opportunity to ask questions and discuss the use of this medication with my physician to my satisfaction.

I understand the risks and benefits of this medication and have received a copy of the Anticoagulation Patient Education.

I understand the importance of my participation in the proper use of this medication.

Taking prescribed dose as directed

Having blood work (PT/INR) done on time as ordered by physician

Notifying my MFHC Provider if I start any new medications or supplements as these may change my warfarin level, requiring additional testing of my PT/INR

Keeping in close contact with physician concerning blood test results (PT/INR) and possible adjustment of warfarin

Contacting the clinic for results and further directions if I have not heard from the clinic within a day of having blood work (PT/INR) (All blood draws should be done Monday through Thursday, avoiding the day before a holiday or weekend, unless special arrangements have been made)

Seeking medical attention for any signs of bleeding, trauma or significant changes

Keeping my physician informed of my current phone number

Giving permission to leave messages concerning my PT/INR and warfarin dosage on my answering machine (or my contact person’s answering machine) if necessary

Seeing my primary care doctor a minimum of every six (6) months

I have read, understand and agree to the above.

Patient Signature _____

Guardian Signature _____

Date _____

Witness _____

DUTIES OF THE C1 CLINIC DOCTOR

Revised 1/2016

During this rotation the resident will be in clinic from 8:00 a.m. to 5:00 p.m. daily, Monday - Friday. C1 Clinic Doc will participate in all specialty clinics as scheduled and follow-up on all patients seen in specialty clinics. Residents may also be asked to follow-up on issues pertaining to specialty clinics the week after C1 rotation since that resident has the greatest awareness of the patients.

1. Review labs daily

- a. See Master Schedule to see which residents are out of town or on night float rotation.
- b. Check and address abnormal lab and messages on Cerner using proxy for residents who are on vacation, or on "out of town" elective, or on night float.
- c. When C1 finds an abnormal result, he/she may contact patient, schedule f/u visit with PMD or refer the result to the PMD.
- d. Forward to MFHC Front Office to schedule appointment as indicated.
- e. If abnormal PAP, forward copy to Jennifer with instructions for appropriate f/u & tracking.
- f. If Pap is normal, note this on patient result card and return chart to front office and staff will mail card to patient.
- g. Warfarin patients are tracked by nursing, to assure appropriate follow-up. After noting any changes to warfarin dose and date for follow-up PT/INR, give chart to nursing staff who will contact patient.

2. Review and Refill Prescriptions

- a. Clinic doc will review all prescriptions refill requests on Cerner for residents on vacation or out of town. Residents who are away are supposed to put a notice on their box, but sometimes they forget. Check the schedule to see who is away and put a notice on their box to prevent prescriptions refills from being placed in their box.
- b. Patients must be seen at least once a year to get non-controlled prescription medications, once every 6 months for warfarin, and once every 1-4 months for controlled substances.
- c. For patients who have not been seen in a timely manner, consider prescribing a limited quantity to allow time for the patient to be seen without running out. Forward to MFHC Front Office Staff with message, "Patient needs follow-up appointment in ___ weeks."
- d. Do not authorize refills if unclear why patient is taking medication.
- e. Only refill specialty clinic prescriptions if patient is seen on ongoing basis otherwise have pharmacy send refill request to PMD.

3. Filling out paperwork for primary care provider

- a. Occasionally there is paperwork that cannot wait until PCP returns from vacation or out of town elective and the clinic doc must complete this.
- b. If unable to complete immediate paperwork because of time constraints or lack of documentation in chart, have front office schedule patient for an appointment.

4. Specialty Clinic Referrals and Tests

- a. Determine if referrals to specialty clinics are complete and appropriate.
- b. Follow-up on tests ordered during specialty clinics.

5. Clinic Responsibility and Practice Management

- a. C1 must complete all responsibilities prior to leaving clinic (last work-in can be scheduled up to 4:45pm).
- b. Collaboration and teamwork are important. Front office and nursing staff look to Clinic Doc for taking lead role in patient care and for being responsible and maintaining a good attitude.
- c. Clinic doc is scheduled to attend the weekly Tuesday clinic leadership meeting which occurs at the MFHC Classroom at 730 am.
- d. Completing the evaluation at end of rotation helps the staff improve the clinic doc rotation.

6. Specialty Clinics and Clinic Times

Generally, all clinics including specialty clinics start at 8 am. Residents are asked to be prompt since most specialists are volunteering their time. The clinic doc sees a limited number of continuity patients to allow time for the lab buggy.

SPECIALTY CLINICS

Allergy Clinic (MFHC):

You will be working with Dr. Renard, an internist specializing in allergy/clinical immunology. During this outpatient rotation, the resident will gain experience in the recognition and proper management of common allergic problems and procedures.

Dermatology Clinic (MFHC):

During this outpatient rotation the resident will gain experience in recognition and proper management of common dermatological problems and minor dermatological surgical procedures. The residents see patients and present them to the dermatologist, discuss management and strategy. All extensive surgical procedures are referred to the Minor Surgery Clinic or Plastic Surgery Clinic using the appropriate referral form. The resident on Dermatology does biopsies while excisions are referred to the Minor Surgery Clinic.

HIV Consultation Clinic (SCHC):

This clinic is designed to promote resident and community understanding of the diagnosis and treatment of HIV disease and its complications. This clinic is conducted at SCHC and run by Dr. Coe and Dr. Villalobos. The Resident participates in the work-up and management of HIV patients on a consultative basis developing their knowledge and skills in the management of HIV patients in their own practice.

Procedure Clinic (SCHC)

The SCHC Procedure Clinic is precepted by family physicians. Residents will learn to perform vasectomies and other minor surgical procedures. Training includes counseling, pre-op exam, and post-op care. Training video and model/instruments are available for the resident to review and practice prior to the clinic, provided by Dr. Namihas.

Practice Management (Private office)

Resident will spend two half days at Mountain View Family Medical Group with coordination by Jennifer Moranda, MD. The experience will primarily focus on Practice Management, with opportunities to meet with the various office staff and physicians to learn how to provide patient care efficiently and effectively in a private practice setting.

Minor Surgery Clinic (MFHC)

During this clinic, residents will work with either Dr. Roitman or Dr. Namihas, learning how to perform minor surgical procedures common in family medicine, including punch biopsies, shave biopsies, excisions, curettage and desiccation and a variety of suture and closure techniques. A training video is available for review prior to clinic. See Dr. Namihas for access.

Plastic Surgery Clinic

This clinic occurs once a month and is supervised by Dr. Wong. Residents will learn how to perform minor surgical procedures which are more complex or cosmetically sensitive.

SPECIALTY CLINICS

During Clinic I and II rotations, time is scheduled in the specialty clinics held either at Mercy Family Health Center or Shasta Community Health Center. Continuity clinic time is maintained throughout the rotation at the minimum of three half-days/week.

Clinic I Specialty Clinic Monthly Frequency

Allergy:	1x
Dermatology:	1x
HIV:	1x
Practice Management	2x
Minor Surgery/Plastics:	3x
Vasectomy:	3x

Clinic II Specialty Clinic Monthly Frequency

Behavioral Science:	2x
Colposcopy:	5x
Dermatology:	4x
GYN:	2x

Allergy Clinic (C1 – MFHC):

You will be working with Dr. Renard, an internist specializing in allergy/clinical immunology. During this outpatient rotation, the resident will gain experience in the recognition and proper management of common allergic problems and procedures. The resident must be present in the allergy clinic at all times during this rotation. The resident does an initial history and examination, and then presents them to the allergist to discuss management and strategy. Attendance at any allergy lectures during this rotation is mandatory. Upon completion of the allergy rotation, a short, written or verbal test is optional pending the discretion of the allergist.

Behavioral Science (C2 – MFHC,)

This involves seeing mental health patients with Dr. Pappas.

Colposcopy Clinics (C2 – MFHC and SCHC):

Training is provided in the management of abnormal cervical pathology under the supervision of family practice faculty. Procedures include Colposcopy, cryotherapy and LEEP. Colposcopy clinic is held four times per month at Shasta Community Health Center and once each month at Mercy Family Health Center.

Residents may also be scheduled at Mercy Maternity Clinic as the schedule allows.

Dermatology Clinic (C1 and C2 – MFHC):

During this outpatient rotation the resident will gain experience in recognition and proper management of common dermatological problems and minor dermatological surgical procedures. This rotation is a “hands-on” experience that depends on the residents to provide direct care, so residents must be present in the dermatology clinic at all times during this rotation. The residents see patients and present them to the dermatologist, discuss management and strategy. All extensive surgical procedures are referred to the Minor Surgery Clinic. The resident on Dermatology does biopsies while excisions are referred to the Minor Surgery Clinic.

GYN Clinic (C2 – MFHC and SCHC):

You will be working with community gynecologists at SCHC and private gynecologists’ offices approximately 15 half-days/month developing appropriate experience in, recognition of, and proper management of common GYN problems and procedures. The resident will see patients and present them to the gynecologist as appropriate to discuss diagnosis and management. GYN surgical patients from the MFHC GYN clinic will be followed on the family practice in-patient service. The resident on C2 or the patients PCP should assist at the surgery with the GYN attending.

HIV Consultation Clinic (C1 – SCHC):

This clinic is designed to promote resident and community understanding of the diagnosis and treatment of HIV disease and its complications. This clinic is conducted at SCHC and run by Drs. Coe, Shiu and Menezes. The Resident participates in the work-up and management of HIV patients on a consultative basis developing their knowledge and skills in the management of HIV patients in their own practice.

Practice Management (C1- Private Office)

This rotation will be incorporated into the C1 rotation with two half days during the PGY2 year and two half days during the PGY3 year. It will take place at a private family physician’s office in Redding. The experience will primarily focus on Practice Management, with opportunities to meet with the various office staff and physicians to learn how to provide patient care efficiently and effectively in a private practice setting. Residents will learn the following skills:

- Effective billing

- Designing a budget and managing overhead costs
- Collections for various insurance carriers
- Assessing practice staffing needs
- Understanding of office manager function
- Personnel management and labor issues
- Employment law and procedures
- Integrating new technologies into one's practice
- Determining value of patient care in one's community
- Assessing customer satisfaction
- Measuring clinical quality
- Tort liability and risk management
- Office scheduling systems
- Use of computers in practice
- Alternative practice models

Vasectomy Clinic (C1 – FPI)

Residents also participate in Vasectomy Clinic, which is incorporated into a procedure training clinic located at SCHC and precepted by family physicians. The goal is to have residents become proficient at performing vasectomies, and all aspects relating to the procedure, including counseling, pre-op exam, and post-op care.

CLINIC REFERENCE BOOKS AND ONLINE RESOURCES

A library is available in the health center with reference texts and computer resources. Please use it and feel free to suggest new acquisitions. All library resources must remain in the clinic.

CONTINUITY OBSTETRICS EXPERIENCE

A. Goals:

Maternity care experience includes rotations on the OB (Obstetric) hospital service and continuity experience through Mercy Family Health Center. Managing a family medicine continuity maternity patient is considerably different than managing patients who are not yours. Following that patient and child is part of what makes family medicine OB unique. The continuity experience is intended to acquaint the resident with maternal-child care from prenatal care through labor and delivery and the post-partum period. The bio-psychosocial elements of a normal pregnancy are important aspects of this experience.

B. Description:

Residents will follow family medicine continuity patient pregnancies over their three years of training. The residency program will track each resident's continuity OB patients and deliveries. Residents will be responsible for reporting to the program all completed deliveries of continuity OB patients.

The primary goal of continuity OB care at the Mercy Family Health Center is for education and exposure to family medicine maternity care through the entire pregnancy including post-partum care of the patient and the newborn. The obstetrics hospital service that is staffed by the family medicine resident physicians provides significant OB inpatient management experience but is otherwise not the same as the continuity care experience. The program has set minimum parameters as agreed upon by the program director and faculty that constitutes a reasonable family medicine maternity care experience for both inpatient OB service rotations and continuity OB care.

Continuity OB patients will be assigned to residents by clinic staff on a rotating basis -- up to a maximum of 15 patients per resident through their duration of residency dependent on continuity patient care demands at Mercy Family Health Center. More commonly, the total assigned continuity obstetric patients during an individual's 3 years of training is about 10. Patient assignment will start approximately at the beginning of the 2nd year of training but as soon as the latter half of the first year. When a new pregnant patient enters the clinic or a resident's established continuity patient becomes pregnant, the patient will be evaluated to make sure she is an appropriate low risk OB patient for the Mercy Family Health Center. Otherwise, the patient may require transfer of care to the Mercy Maternity Clinic for high risk care if indicated. The resident will provide the prenatal care if at all possible. If the patient is deemed high risk, the resident has the option of following along with the obstetricians at the OB clinic and attending the delivery. Academic advising will provide feedback regarding OB continuity cases and deliveries. Inpatient precepting of all deliveries will occur with contracted community Family Medicine physicians or with the Mercy Medical Center contracted Obstetricians. MFHC prenatal patients will have chart audits every trimester. Cases of interest may be presented at periodic noon OB Conference or Morning Report by the continuity provider or the OB back up partner.

C. Duties:

The following program guidelines outline maternity care expectations and duties for the family medicine resident. The numbers listed represent the minimum requirement for a resident physician completing this program to be deemed competent for that respective level of maternity care. The minimum numbers set forth do not necessarily represent competency for providing care. Competency is determined separately for each individual resident. All residents are expected to achieve the minimum competency level of Basic Maternity Care by the end of training. Most residents will achieve Comprehensive.

Current program inpatient service care and clinic care obligations DO NOT allow an individual resident to selectively cease maternity care services once they have achieved the Basic Maternity Care competency level.

	<u>Basic</u>	<u>Comprehensive</u>	<i>Advanced Maternity Care</i>
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	Maternity Care	Maternity Care	<i>(not currently available at this program)</i>
Prenatal encounters (all prenatal visits – MFHC, MMC, L&D triage, maternity ED evals)	150	150	250 (including at least 100 high risk encounters)
Continuity Cases	5	10	10
Continuity Deliveries	3	10	10
Vaginal Deliveries	20	50*	80
Cesarean Assist	5	10	10
Postpartum Care	5	10	10
Cesarean primary surgeon			70
Primary Cesarean			40
Repeat Cesarean	N/A	N/A	30
Dilatation and Curettage			10

* Mercy Medical Center Redding - current requirement for Family Medicine Obstetrics delivery privileges is a minimum of 50 low to intermediate risk vaginal vertex deliveries.

1. **OB Partners:** Residents will establish their own OB partners among themselves generally within their own residency class and in pairs. Occasionally a partner group may need to be comprised of 3 residents. Each resident is expected to assist their OB partner throughout each other's OB continuity patient care needs regardless of any one partner's status in completion of the minimum required numbers -- e.g. an OB partner cannot say they will not cover their partner simply because they feel they have completed their own requirements.

OB resident partners may be required to serve the purpose of periodic peer review of care through chart audits as well as continuity care clinic visits and deliveries, post- partum care, and newborn care as arranged through the partners. The partner's name(s) should be noted in the chart – the most appropriate locations to note the OB partner in Cerner are the OB To-Do-List and/or list the OB partner at the top of each visit note.

2. **Continuity Care Case Credit:** Residents must follow a minimum of 10 continuity patients to meet Comprehensive Maternity Care requirements or 5 patients to meet Basic Maternity Care requirements. Two OB antepartum visits will constitute a minimum requirement for continuity of care case credit for patients seen at Mercy Family Health Center or Mercy Maternity Clinic. Each partner may receive credit for a continuity case if they have *each* seen the patient at least 2 times during the pregnancy for antepartum care. Continuity patient triage visits on L&D may count toward overall prenatal care totals but not toward Continuity Care Case credit. This allows courtesy triage of continuity patients on L&D by the on-call resident even if they are not the OB partner.

3. **Continuity Deliveries:** It is expected that each resident will attend a minimum of 3 deliveries of their OB continuity patient panel to achieve the minimum requirement toward Basic Maternity Care competency. An OB partner may still receive credit for a continuity care delivery of one of their partner's patients even if they have not achieved credit for antepartum visits for that patient. This is viewed as a reasonable credit considering that communication of continuity patients among partners will occur on a regular basis as would occur in normal

practice outside of residency. Patients should be familiar to an OB partner even if they have not seen the patient in clinic. A continuity patient who is delivered by a covering resident on the OB service team (who is not the OB partner) at the time of delivery will NOT count as a continuity care delivery for anyone -- this is to encourage a true continuity care experience for resident training and for patients. Such a delivery however, would still count as a general delivery for the covering resident. Residents are encouraged to attend as many of their own continuity patient deliveries as possible - not just the minimums. The continuity care experience is healthy for the patient, educational for residents, and establishes on-going care needs as well as additional patient recruitment for the clinic when a patient has a good care experience to share with friends and family.

4. **Call Coverage for Continuity OB Patients:** For continuity OB patient care, the primary resident physician has a professional responsibility to maintain knowledge of their obstetrical patients' gestational dating and care plans and anticipate needed communication with their OB partner. It is each resident's responsibility to make appropriate arrangements for coverage of their continuity patients with their OB partner. **THIS MEANS COMMUNICATING OFTEN WITH THE OB PARTNER WHEN A MATERNITY PATIENT IS APPROACHING TERM.** The OB inpatient service team may be utilized in situations when the primary resident physician and the partner are known to be unavailable to attend an expected term delivery or in unanticipated scenarios (i.e. preterm labor). The assigned resident may not be immediately available for such scenarios and the patient should be deemed high-risk. Transfer of care to the inpatient OB team should occur. While not required after transfer of care, the primary assigned resident can still follow through with the care if they are able to do so.

5. **Missed Continuity Deliveries.** Residents will inform the program of any missed continuity deliveries and the reason. Acceptable reasons for a missed delivery may include being on vacation, away elective rotation, post-call status, illness, or off duty and out of town - for the primary resident AND OB partner with prior notice to the OB service team. Other reasons that may be considered acceptable will be determined by the residency program director and faculty on a case by case basis. A trend of repetitive use of the "off duty and out of town status" for missed deliveries by both the primary resident AND OB partner will be addressed at the discretion of the program director and faculty. See item 9.

6. **Assuming Care or Transfer of Care.** Residents are expected to assume care of their post-partum patient and newborn if they miss the delivery for reasons as stated above but otherwise are available in the following days. If a resident needs to transfer the post-partum care of their patient and newborn to their OB partner or other resident service for appropriate reasons, verbal communication of that transition is expected.

7. **Continuity Newborn Care.** Newborns of continuity OB patients will be cared for by the continuity doctor (unless unavailable for other reasons as stated above) in the hospital as part of the Family Medicine inpatient service. The delivering resident shall inform the Family Medicine attending immediately following delivery and assessment of the newborn.

8. **High Risk Patients.** Prenatal patients who become high risk or with whom questions arise should be appropriately discussed with an OB attending and/or referred to the Mercy Maternity Clinic for care as appropriate.

9. **Consequences of deviation from established program guidelines.** Guidelines of residency training are intended to establish competency for medical knowledge and independent practice upon completion of the program. This competency includes professionalism. Consequences of deviation from the program guidelines may include additional call duties, reduced elective rotation time, and/or pursuing the due process procedure as outlined in the Residency Handbook.

MISSION PROVIDER SERVICES

Patients/clients living at four of the Mission Provider Homes in Redding receive care through Mercy Family Health Center. Mission Provider Services, Inc. provides 24/7 assisted living care for adults with special needs. Regulation requires that each patient have:

- 1) An Annual Physical Exam – to be done at MFHC and dictated.
- 2) An evaluation and orders reviewed/signed every 60 days.

MFHC provides the 60-day evaluations in the group home, rather than transporting the residents to MFHC. This helps improve the care that the patients receive, and has expanded the resident education on caring for adults with special needs.

Each MP home has 6 residents. Two of the homes have higher acuity patients (i.e. G-Tubes, suprapubic catheters) and have a (N) designation. A registered nurse helps oversee all of the care provided to patients in all four homes.

Nursing (N)

Wilvern 6

Amir (6)

Habilitative (H)

Showboat (6)

Herbscenta (6)

60 Day Home Visits

These visits are done by an attending and a resident, usually the C1 Resident. All of the scheduled visits are in the afternoon (2-5 pm approx.) to accommodate the patients' Day Program requirements. The residential care providers and an RN are in attendance at the home for the duration of the visit, and each patient's complete record is available.

What to bring:

- 1) Portable otoscope/ophthalmoscope (in the locked cabinets in the MFHC nursing lab).
- 2) House-specific yellow folder (includes driving directions, billing slips, list of patients to be seen). Kept in locked cabinets in the MFHC nursing lab also.
- 3) Stethoscope

Upon return:

- 1) Turn in the Progress Note copies to Medical Records to be filed in patients' charts.
- 2) Turn in the purple billing slips.
- 3) One of the Mission Provider RNs will deliver copies of the medication orders the following day, which should be filed in the patients' charts.

- 4) Resident MUST log the patient visits into New Innovations, under NURSING FACILITY VISIT in order to get continuity patient visit credit. MFHC Administration manually enters the patient visits at the end of each month.
Return the yellow folder and otoscope/ophthalmoscope to the locked cabinet in the MFHC lab.

NEWBORN CARE

When a MFHC patient delivers a baby, newborn care is provided by the Family Practice Service (FPS), whether the prenatal care was provided by MFHC, a private OB, or the Maternity Clinic. It is expected that the resident/physician involved in the prenatal care/delivery will perform the Newborn H&P and in-hospital care, with his/her OB partner covering as needed. The FP attending will provide back-up.

A patient who does not receive her primary care or prenatal care at MFHC may arrange ahead of time for a MFHC physician to provide newborn care for her baby. In this situation, the patient will notify the nursery staff who will then notify the identified MFHC resident/physician directly when the baby is born. In the event the resident/physician is not available (evenings, weekends, & vacation) the nursery staff will notify the Pediatric resident, who will either admit the baby and perform the H&P (after hours) or contact the FPS resident to do so (daytime/weekdays). The newborn will be on the FPS, with the FP attending providing back-up.

If a patient is not established at MFHC and has not pre-arranged for a MFHC resident/physician to provide newborn care for her baby, then the newborn care is provided by the Pediatric Service, with the Pediatric/Nursery attending as back-up.

OSTEOPATHIC MANIPULATION THERAPY

Osteopathic manipulative medicine is done at the family health center under the following policies:

- Osteopathic medical students will only be allowed to do OMT under the direct supervision of osteopathic faculty
- Only osteopathic residents, who have graduated from accredited Osteopathic schools, have had the appropriate basic and applied training to perform OMT, and have demonstrated proficiency in OMT are eligible to perform OMT as residents in our program
- Direct supervision of OMT by osteopathic faculty is required until competency is demonstrated and documented using the OMT Competency Form
- Periodic direct supervision, or more frequently as deemed appropriate, will occur by osteopathic faculty

PRACTICE MANAGEMENT

Residents are an integral part of the operations at the health center and participate in the bi-monthly Clinic Staff / Resident Meetings designed to review and improve both the clinical and business performance of the center, and provide a forum for practice management teaching.

Topics covered in precepting at the Family Practice Center and in Resident/Staff meetings include team functioning, nursing responsibilities, scheduling, billing, chart management, quality control/peer review, laboratory, staffing, and equipment purchase and upkeep. (See - Management of Health Systems above).

PROCEDURE REQUIREMENTS AT MFHC

Prior to performing procedures at MFHC, providers will perform and document in the clinic note the following:

1. Review the patient's past medical history and comorbidities and perform a physical examination to assure no contraindications for the procedure.
2. After discussing and reviewing risks, benefits, and alternatives of the procedure with the patient, write an order in the chart requesting the nurse to have the patient sign a consent form for the procedure(s). The order will specify the name of the procedure(s) and the site(s), if applicable.
3. Perform a surgical "time out" to confirm the following: the patient's identity using two identifiers, the correct procedure, the correct site and side (if applicable), the correct position of the patient, and the correct equipment available in the room. All members of the healthcare team must be in agreement and their names will be listed on the Procedure Note.
4. Document the following in the procedure note: the date, time, pre- and post- procedure diagnosis, attending, resident, anesthesia, findings, complications, EBL, and informed consent, including risks, benefits, and alternatives. If applicable, it will also include sedation, drains, and specimens.

These steps will be taken for the following procedures:

- Nail Removal
- Excision of Lesion
- Curettage & Desiccation
- Punch Biopsy
- Shave Biopsy
- Endometrial Biopsy
- Circumcision
- Colposcopy
- Cryo-ablation of the Uterine Cervix
- Abscess Incision and Drainage

SKILLED NURSING FACILITY VISITS

Each second- and third-year resident is required to follow a minimum of two SNF patients. Dr. Nena Perry coordinates the patient assignments; she and other faculty provide back-up. SNF patients should be seen each month at their facilities. These visits are to be documented in New Innovations. Billing forms will be available as well when the patient is seen with or by an attending. [Nena Perry, MD will co-sign Skilled Nursing Facility patient notes](#)

III. POLICIES AND PROCEDURES

ADMISSIONS AND CONTINUITY OF PATIENT CARE

When a resident (or faculty member) sees and admits his/her continuity patient from MFHC, it is the responsibility of that PCP (Primary Care Physician) in the clinic to write admit orders and the admission H&P. If another provider is seeing the patient and the FP service resident is available, the FP service resident should do admit orders and the H&P. If the FP service resident is not available, then admit orders and the H&P are to be done by the provider seeing the patient at clinic. It is the duty of the physician writing the admission orders to contact the FPS preceptor at the time of admission.

Whenever a resident's patient is admitted to the hospital, he/she is expected to make daily rounds and work with the in-patient team in clinical decision-making and disposition unless the resident is on an away elective, vacation, or in-patient service that precludes such visits.

APPEARANCE

A Physician's appearance has a significant impact on how others gauge professional competence, and judge the residency and hospital. Residents will present a professional appearance during working hours in compliance with the Mercy Medical Center Human Resources Policy Manual.

BILLING AND DOCUMENTATION

Notes should be completed before leaving clinic. If circumstances prevent an entire note from being completed, there must be an assessment and plan saved on each patient before the end of the day. The entire note, including Medication Reconciliation and visit summary must be completed within 72 hours. Billing charges must be submitted within 3 days, after the 5th day charges are dropped.

EVALUATIONS

MFHC conducts a health center patient evaluation annually. The health center staff evaluates the residents on communication (Milestone C-3). The resident on the Clinic I rotation completes an evaluation assessing the quality of the clinic experience, including issues such as staff support, clinical experience, rotation structure. In addition, there are health center management meetings held throughout the year with resident participation, to discuss ongoing clinic issues.

GRIEVANCES AND COMPLAINTS

- At times, the resident is placed in difficult positions that may, or may not, be related to any action on his/her part. Often such issues can be resolved by talking them through with the involved parties with or without a neutral third person. But sometimes they cannot. The program is committed to being supportive and fair in its response to problems and utilizes policies of the Human Resources Department to reconcile the problem. We recommend the following first steps in resolving issues in the clinic. First, discuss the issue with Sharon Babcock, RN (Clinic Manager). For issues relating to preceptors, resident education, or patient care issues, contact Steve Namihas, MD (Medical Director). You may also check our grievance policy. If the issue is still not resolved you may contact the residency director Duane Bland M.D.

Where **not** to air grievances:

- To nurses in public areas
- To medical students in public areas
- To the hospital's Medical Director or Administration, even if the problem seems to be their responsibility.
- To patients, especially in public areas

If you believe a significant issues exists that impacts the safety and quality of patient care, a written report should be made so that the appropriate analysis and corrections are made.

HOLIDAYS AND VACATIONS

The Mercy Family Health Center is closed on hospital holidays. Mercy Medical Center observes these holidays:

- New Year's Day
- Martin Luther King Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving
- Day after Thanksgiving

- Christmas Day

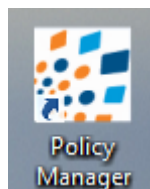
Appropriate "leave forms" must be completed and authorized by the Residency Director and the Clinic Manager at least twelve weeks prior to when the leave is effective.

In addition to scheduled vacation time, residents have two Personal Days (mental health days) each year (July 1-June 30). For more detailed information about Vacation Days and Personal Days, see the above section on PTO. Only one Personal Day is allowed during a given rotation. Scheduled health center clinic time must be covered.

Once a year, however, residents may make one unscheduled clinic change with at least 10 working days notice so staff can contact patients prior to their appointments. One-time clinic changes may be done for personal time off (PTO), or work reasons: CME, interviewing for a future job, or elective rotation time. Additionally, the change must be approved by Sharon Babcock, RN to make sure that it will not affect clinic staffing. The residency office has the appropriate paperwork. We ask that you begin the paperwork as soon as possible to make these days as smooth as possible for all concerned.

MEDICAL STUDENTS

Students rotating at through the residency program are coordinate through the residency administrative office in conjunction with the Medical Staff office. Mercy polices regarding medical students may be found under the Policy Manager icon on hospital computer desktops:



Rotation specifics are coordinated through the residency office. We only take senior students, or third year students who have completed core rotations and are from LCME or AOA approved schools. Most clerkship's involve two weeks of Family Practice Clinic and two weeks of inpatient care.

Students should always be introduced to the patient by the resident or attending, acknowledging that he/she is a medical student on a clerkship with us, and requesting the patient's consent to have the student participate in his/her care.

History and exam findings must always be discussed with, and verified by, the resident or attending. Student chart entries are not acceptable documentation – supervising residents and attending physicians must provide their own documentation of care.

TIPS FOR TEACHING MEDICAL STUDENTS

- The resident / preceptor should offer guidance prior to the patient encounter by reviewing the problem and drug list in the chart and making any comments about the patient and the focus of this visit.
- The student will observe your patient encounters. When considered ready, the student will take the lead role of gathering the data. The student should be observed and guided at all times. Once the preceptor is comfortable with the student's ability he/she may then have the student see selected patients before his/her personal evaluation. Introduce the student to the patient and tell the patient you will return.
- Students should write up the encounter using the SOAP format and the preceptor (resident and/or attending) will review and critique the student's note. The preceptor (resident and/or attending) must chart a complete note on the same page as the student and/or dictate on the patient. Attendings must provide resident and patient care oversight as usual.
- Feedback should be given to the student on each case and suggestions for improvement made.
- By the end of the rotation, the preceptors will evaluate and grade the student, using the copy of the school's evaluation form. This should be discussed with the student for their benefit or done after the rotation.
- Students should always be assigned to work with a core faculty member or Mercy Medical Center Resident under the supervision of the attending physician

EVALUATION OF MEDICAL STUDENTS

Immediate feedback (Formative Evaluation) to the student from the supervising resident or attending is always encouraged as part of the learning process.

In addition, the evaluation form provided by the medical school will guide the official feedback process (Summative Evaluation). Dr. Namihias will be responsible for completing MFHC evaluation

SUPERVISION OF MEDICAL STUDENTS

Patient care provided by medical students, and FNP/PA students shall be under the supervision of clinical teaching faculty. Such care shall be in accordance with the provisions of the Mercy Redding Family Practice Residency Program approved by and in conformity with the

Accreditation Council of Graduate Medical Education.

All students documenting in the medical records will indicate their student status (e.g. “MS IV, PA-S, FNP-S”). Student notes do not suffice for adequate clinical documentation. Student notes must be reviewed, corrected and countersigned by the attending or resident physician providing supervision. **The only documentation by medical students that may be used by the teaching physician is their documentation of the review of systems (ROS) and past family social history (PFSH). The teaching physician may NOT refer to a medical student’s documentation of physician exam findings or medical decision-making in his/her personal note. The teaching physician must verify and re-document the history of present illness (HPI) as well as perform and re-document the physical exam and medical decision-making activities of the visit service. This rule also applies to the documentation by other kinds of students, e.g., physician assistants and nurse practitioners.** The attending or senior resident physician must countersign all orders written by medical students before being accepted by the nursing staff. Students may not perform any examinations, diagnostic tests, procedures (including surgical assisting), or therapy on any patients without the approval of the attending physician. A qualified resident or attending physician must directly supervise all procedures.

Students participating in clerkships with the Mercy Redding Family Practice Residency Program shall be currently enrolled in a school approved by the Liaison Committee on Medical Education, the American Osteopathic Association, or the Commission on Accreditation of Allied Health Education Programs. Medical Students shall provide certification of malpractice and liability coverage from their sponsoring institution prior to clerkship participation, as well as written approval from the Medical School Dean’s Office. The Medical School must have a written agreement with Mercy Medical Center. The School must provide any evaluation requirements.

Student rotations sponsored by the Residency Program will be coordinated and managed by the office of the Director of the Family Practice Residency. All involved **attending physicians and** nursing units will be notified of students and their dates of rotation at Mercy Medical Center Redding prior to their arrival.

NURSING ORDERS

Verbal nursing orders should only be used in emergency situations. All non-emergent nursing orders must be written in the patient chart in the “Orders” box located in the bottom right corner of the clinic record. After signing the order, the provider should then turn on the white flashing nurse call button in the patient’s room, and take the chart to the nurses’ station and place it in the chart holder that corresponding to the room number. After completing the order, the nurse will return the chart to the provider or place it in his/her box.

PAP TEST WITHOUT ENDOCERVICAL CELLS

If a MFHC patient has a Pap test result with no endocervical cells, the PMD or covering physician will contact the patient by phone to inform her that she will need to be scheduled a follow-up Pap test in 6-12 months. For pregnant patients, this can be performed during the post-

partum follow-up. If a Pap test result indicates “unsatisfactory for evaluation”, patient should be contacted to schedule a repeat Pap test at the next available appointment.

DOCUMENTING FOLLOW-UP

Note on the Pap test report that the patient was contacted and when she was advised to schedule repeat Pap test. Give a copy of the report to Jennifer O’Connor who will place report in reminder file to assure follow-up.

See below for more details regarding Pap test results with no endocervical cells.

CAUSES

This may occur in pregnant or post menopause patients or may occur due to poor sampling technique.

PROPER SAMPLING TECHNIQUES

Broom-like Devise

- When using the **broom-like devise**, place central bristles into the endocervical canal and **rotate clockwise 5times**.

Endocervical Brush

- Increases the yield for collecting endocervical cells.
- Place brush so bristles closest to the examiner are inserted to the level of the external cervical os.
- **Rotate 180 degrees in one direction**.
- The endocervical brush sampling should be done **after** using the plastic spatula or the broom-like device to minimize bleeding done during sample collection.

ASCCP RECOMMENDATIONS IF NO ENDOCERVICAL CELLS ON PAP

REPEAT PAP IN 6 MONTHS IF

- Any abnormality in the last two Paps (ACS-US or worse)
- Pos high risk HPV test within the last 12 months
- Inability to clearly visualize or sample endocervical canal
- Insufficient frequency of prior screening

REPEAT PAP IN 12 MONTHS

If no endocervical cells and none of the above applies

It may not be necessary to continue repeating Pap tests every 6-12 months for no endocervical cells if proper technique was used, results indicate “satisfactory for evaluation”, and HPV results are repeatedly negative.

We have adding a check box to our Routine GYN exam note to indicate “Endocervix clearly visualized and sampled during Pap test”

PATIENT DELIVERED PARTNER THERAPY

Although it is ideal for the partner to be seen by a medical provider before receiving antibiotic treatment, groups such as the AMA recognize the benefits of patient delivered partner therapy (PDPT). The effectiveness of this practice was published in the New England Journal of Medicine: Golden MR, Whittington WL, Handsfield HH, et al. Effect of expedited treatment of sex partners on recurrent or persistent gonorrhea or chlamydia infection [*N Engl J Med* 2005;352:676-85](#). **Be sure if you choose to write a prescription for PDPT at MFHC, please make sure that a separate prescription is written for the patient's partner.** Do not add extra pills onto the patient's prescription. A patient handout to give to a partner explaining Chlamydia and its treatment can be found in the preceptor room at MFHC. The icon for the handout has been placed on the "desktop" screen of the preceptor's computer. Click on the icon and print the handout.

PHONE MESSAGES AND RESPECTING PRIVACY - HIPAA

The HIPAA Privacy Rule permits health care providers to communicate with patients regarding their health care at their homes, whether through the mail or by phone or in some other manner. In addition, the HIPAA Privacy Rule does not prohibit healthcare providers from leaving messages for patients on their voice mail or answering machines. However, to reasonably safeguard the individual's privacy, covered entities should take care to limit the amount of information disclosed on the answering machine, voice mail or answering service. The HIPAA Privacy Rule permits health care providers to leave a message with a family member or other person who answers the phone when the patient is not home, and to disclose only limited information to family members, friends, or other persons regarding an individual's care, even when the individual is not present.

Healthcare providers should also use professional judgment to assure that such disclosures are in the best interest of the individual, and limit the information that is disclosed.

Don't-Leave a message with a third party that provides any identifying details about the patient or his condition, whether speaking on the phone to an individual, via voicemail or an answering machine. This is a breach of confidentiality. When calling a physician about a patient, never leave a message with a third party, on voicemail or an answering service that provides any identifying details about the patient or their condition.

Do-Leave a brief message requesting a call back from the patient. Leave a message for the physician requesting a call back (urgent or not urgent) regarding a patient matter.

In situations where a patient has requested that the healthcare provider communicate with him in a confidential manner, such as by alternative means or at an alternative location, the healthcare provider must accommodate that request, if reasonable. For example, the U.S. Department of Human Services (DHS) considers a request to receive mailings from the healthcare provider in a closed envelope rather than by postcard to be a reasonable request that should be accommodated. Similarly, a request to receive mail from the healthcare provider at a post office box rather than

at home, or to receive calls at the office rather than at home are also considered to be reasonable requests, absent extenuating circumstances.

PHONE CALLS FROM HOSPITAL OPERATOR AFTER HOURS

Calls to MMC Operator requesting to talk with a Resident Physician

Caller:
Physician

168

Caller:
Patient
or
Lab/Radiology after
hours

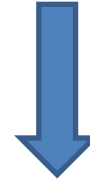


Specific Resident Requested:

Call appropriate Resident Beeper
(see photo sheet with beeper numbers)

Rotation/Service Specific request:

- **Pediatrics:** Beeper # 951
- **Obstetrics:**
 - Day: Call Ext. 7380
 - Night: Call Beeper # 951
- **Adult Medicine:** Beeper # 987
- **Family Practice:** Beeper # 963



Mercy Family Health Center Patients
(includes patients followed by residents
and core faculty including Drs. Bland,
Coe, Namihas, Perry, & Roitman)

- Weekdays - 8 am – 4:30 pm: Instruct to call MFHC @ 225-7800
- Evening hours and or weekends: Operator to call Beeper #963

Shasta Community Health Center Resident Patients

- Weekdays 8 am – 5 pm: Instruct patient to call SCHC @ 246-5710
- Evening hours or weekends: Operator to call Beeper #963

Not followed at MFHC or by Residents at SCHC:

Patient should contact their own physician (or ED in event of an emergency). For patients followed by non-residents at SCHC, they should call 246-5710.

PRESCRIPTIONS

Mercy Family Health Prescription Refill Guidelines

Objectives for prescription refills:

1. **Patient access to system.** Starting with preferred primary: pharmacy, EHR patient portal, and phone.
2. **Communication with the pharmacy.** Primarily by fax or electronic prescribing via EHR.
3. **Decision-making.** Primary decision making for refills will be with the physician. All resident patient refill requests shall be done by the patient's assigned primary resident or the covering clinic doctor resident when the former is otherwise unavailable. Secondary decision making may be done by qualified nursing staff within the outlined guidelines for faculty physician patients (with the exception of controlled substances which should only be determined by the physician).
4. **Notification of the patient.** The pharmacy will be the primary entity to notify the patient regarding a prescription refill. The physician or clinic staff may additionally notify the patient if there is reason for a denied refill due to other needs such as a prolonged interval since the last office evaluation and therefore need for a follow-up patient visit at the clinic.
5. **Documentation.** Done within the EHR by the decision-maker at the time a prescription refill is granted or denied.

General Guidelines:

Please note these are *guidelines only* and not strict rules to supplant good clinical judgement.

1. All schedule II controlled substances currently require a printed prescription on designated schedule II control substance paper and must be hand carried to the pharmacy by the patient. EHR compliance for e-prescribing controlled substances is anticipated in the future.
2. Up to 3 months (3 separate 1 month prescriptions) of controlled schedule II substances for pain management medications may be given to patients in accordance with the clinic's pain management policy when appropriate for the patient. Schedule II stimulant medications may be prescribed in a similar fashion.

3. All other prescriptions may be faxed, e-prescribed when allowed (some scheduled substances still not currently allowed to e-prescribe), printed and signed on paper via the EHR for patient to carry to the pharmacy, or called to the pharmacy.
4. All patients on a chronic prescribed medication (non-controlled substances) should be seen for an office visit evaluation **at least once annually**. Chronic prescribed medication shall include any medication that is taken daily, weekly, or monthly on a regular basis. Some medications and medical conditions may require more frequent visits such as anticoagulation management, chronic substance management with opiates for chronic pain, uncontrolled or poorly controlled diabetes, poorly controlled hypertension, poorly controlled lung disease, etc.
5. Some medications require periodic basic laboratory monitoring via blood and or urine testing. The guidelines are intended to represent a MINIMUM expectation of monitoring for some common conditions. Physicians will need to assert clinical judgement for more frequent monitoring on a case-by-case basis.
6. Three months quantity for some prescriptions is appropriate when allowable by insurance and stability of the medical condition for which the medication is being prescribed. Maximum refills for any medication can be up to a year with the exception of scheduled II substances which can be no more than 3 months. Some patients on lower scheduled controlled substances with clinically stable conditions may be allowed greater than 3 months of refills at the provider's discretion. It is encouraged however that any patient on a scheduled medication lower than schedule II should be having more frequent office visits than the once annual minimum as stated above.
7. In regards to refill requests on medications in which the patient was last seen a year or more previous, refills may be provided in 30 day supply or less (non-controlled substances) until the patient can be seen for re-evaluation. Some exceptions may apply on a case-by-case basis and should be reviewed with an attending faculty physician.
8. If a patient requests refill on a medication, and based on chart review the patient has not been compliant with taking the medication or may have had care elsewhere and now returning to this clinic, the medication refill should be denied and the patient should be required to have an office visit. This may also apply to an established patient requesting a refill of a medication that is no longer on their active medication list.

Refill Guidelines by medication/condition.

These are the *MINIMUM* requirements as related to refills of prescribed medications. Many conditions need more steps in management to achieve best clinical practice. Please consider patient compliance and stability of their medical condition(s) when making refill decisions. If in doubt, please ask the advice of an attending physician.

Indicated maximum refill durations include the first prescription (Rx).

Example: 1 month quantity of a medication with 5 refills would account for 6 months of medication.

Medication Types	Common associated medical conditions	Quantity per Rx	Max duration refills	Minimum Requirements
ACE inhibitors	Hypertension	Max 3 month	1 year	Min annual visit if controlled condition.

ARBs	Heart Disease Renal Disease	supply per fill		Min annual Basic Metabolic Panel and urine protein (UA).
Benzodiazepines	Anxiety Acute seizure management	Max 1 month supply per fill*	3 months	Min Q 3 month office visits. * Some historically stable patients may have reason for less frequent visits.
Beta-Blockers	Hypertension Heart Disease Migraine Prophylaxis	Max 3 month supply per fill	1 year	Min annual visit if controlled condition. Min annual Basic Metabolic Panel and urine protein (UA) for HTN or heart disease.
Birth Control	Birth Control Menstrual Dysfunction	Max 3 month supply per fill	1 year	Min annual office visit. Pelvic and pap exam as per national guidelines.
Calcium Channel Blockers	Hypertension Heart Disease Migraine Prophylaxis	Max 3 month supply per fill	1 year	Min annual visit if controlled condition. Min annual Basic Metabolic Panel and urine protein (UA) for HTN or heart disease.
Hypnotics (controlled ex: Ambien, Lunesta, temazepam) (non-controlled ex: diphenhydramine, doxylamine, trazadone, melatonin)	Insomnia Sleep Disturbances	Max 1 month supply per fill controlled substances 3 month supply non-controlled substances**	6 months	Min Q 6 month office visits.**
Insulin	Diabetes	Max 3 month supply per fill*	1 year	Min Q6 month office visits.* Min Q 6 month HgbA1C and annual urine microalbumin with protein/creat.
Neuropathic (ex: gabapentin, Lyrica, amitriptyline or other TCAs. Please note Lyrica is a schedule V controlled substance.)	Neuropathy Diabetes Idiopathic Post herpetic Neuralgia Chronic pain management	Max 3 month supply per fill	6 months	Min Q 6 month office visits. Labs as per diabetes guidelines if DM diagnosis. Documented monofilament testing annually for diabetics.
Oral diabetes medications	Diabetes	Max 3 month supply per fill*	1 year	Min annual office visit.* Min annual HgbA1C and urine micro-albumin with protein/creat.
Psychotropics (non-controlled antidepressants, anxiolytics such as buspar or hydroxyzine, mood stabilizers, antipsychotics)	Depression Anxiety Mood Disorders Psychosis	Max 3 month supply per fill*	1 year	Min Q 6 month office visits. Exceptions for once annual visits may exist for some patients but will be rare in our clinic setting. * 1 st gen antipsychotics and some 2 nd generation require blood monitoring – please discuss with an attending physician.
Schedule II controlled substances (ex: opiates, stimulants)	Pain Management ADHD / ADD	Max 1 month supply per fill***	3 months	Min Q 3 month office visits. Min annual urine drug screening for chronic pain management. See chronic pain management policy.

Statins	Hypercholesterolemia	Max 3 month supply per fill	1 year	Min annual office visit. Consider annual Lipid panel but not required. LFTs only if clinically indicated.
Thyroid Replacement	Hypothyroidism	Max 3 month supply per fill	1 year	Min annual office visit. Min TSH lab test annual.

*Some patients with chronic conditions such as diabetes and hypertension may have good control of their conditions which can be seen in their history. A once annual office visit can be appropriate for these patients. This may include some patients that take a benzodiazepine for acute anxiety but historically their usage pattern is very much limited to as needed and as an example a prescription of #20 lorazepam with 1 refill lasts a year. However, please keep in mind our clinic setting which tends towards more patients with uncontrolled conditions and therefore need for more frequent office visits such as quarterly or more frequent. Good clinical judgement is always required.

**Please consider more frequent office visits (such as Q 3 months) than the stated minimum with controlled hypnotics such as Ambien (zolpidem).

***If a treating physician is seeing a patient for controlled substance management whose primary care doctor is otherwise unavailable, it is recommended that only 1 month of a chronic controlled medication be prescribed until the patient can follow-up with their primary doctor. Some exceptions may certainly occur -- acute change in condition or previously well outlined plan of medication adjustment in the prior chart documentation -- but in most cases there should be *no changes in dosing or quantity* of the 1 month supply of a chronic controlled medication by the covering physician.

Medical Marijuana

In agreement with Federal Law, MFHC providers will not write prescriptions for medical marijuana.

PRODUCTIVITY AND PATIENT PANELS

1. According to the ACGME program requirements:

Residents must provide care for a minimum of 1650 in-person patient encounters in the FMP site. The majority of these visits must occur in the resident's primary FMP site. One hundred sixty-five of the FMP site patient encounters must be with patients younger than 10 years of age. One hundred sixty-five of the FMP site patient encounters must be with patients 60 years of age or older.

REFERRAL PROTOCOL

In the past, we have received complaints from consultants regarding the lack of pertinent information when patients are referred from MFHC. Because of this problem, many consultants now refuse to accept referrals from our clinic. To address this issue, we have referral protocol,

which all clinic providers must follow when obtaining consultation **outside** of the residency clinic.

1. Resident cases must be discussed with the clinic attending physician prior to referral.
2. Residents must complete the Cerner referral form and have the clinic note sent with the referral so the consulting physician will have pertinent information when seeing the patient.
 - a.
3. The clinic note accompanying the referral note must include the following *pertinent* information:
 - a. The patient's general medical condition and current medical status
 - b. Past medical information
 - c. Medication list
 - d. Prior studies, treatments, and procedures
 - e. Any other information that would assist the consultant

REPORTABLE CASES

California law mandates that all health care practitioners make a formal report to the relevant authorities when encountering cases in which there is:

- Suspected Child Abuse: (physical, emotional, neglect, etc.): A telephone report is required immediately or as soon as practically possible to the Child Protective Services Agency of Shasta County, and a follow-up written report is to be made within 36 hours.
- Suspected Dependent Adult/Elder Abuse: (physical, neglect, abandonment, fiduciary, etc.): A telephone report is required immediately or as soon as possible to the Adult Protective Services Agency of Shasta County, and a follow-up report is to be made within two (2) working days.
- Suspected Violent Injury: (homicide, assault, gunshot, stab wound, choking, lacerations, bruises, etc.): A telephone report of previously unreported injuries must be made immediately or as soon as practically possible to the law enforcement agency (i.e. police) in the jurisdiction in which the injury occurred, and a follow-up written report is to be made within two (2) working days.

Note that simple, standardized forms are available in the family health center (MFHC) for use in fulfilling the written reporting requirements described above.

- Reportable Diseases and Conditions: (communicable diseases, STDs, Hepatitis, TBC, etc.): Telephone, fax and/or written reporting of certain diseases to the Shasta County Public Health Department are mandated. A reporting form is available in each family health center and in the hospital that delineates the specific reportable diseases and provides a listing of the required reporting modes (e.g. some diseases require immediate telephone reports, other require reports by phone and by mail, etc.).

SURGICAL ASSISTING POLICY

One of the ways the program provides surgical training is by having residents assist in the surgeries for surgeons who precept at MFHC. These patients may or may not be seen at MFHC for their primary care. The order of priority for determining which resident will provide this service is as follows:

1. Resident who may be providing primary care for that patient
2. Resident on surgical rotation
3. FPS resident if not the only senior covering inpatient services

At times, the program may not be able to identify a resident who is available to assist surgeons operating on patients not seen at MFHC. The clinic manager or clinic director will make the final determination.

But when patients who do receive their primary care at MFHC are referred for surgery, these patients are the responsibility of the clinic. A surgical assistant will be located using the following order of priority:

1. Primary care provider for that patient
 2. Resident on surgical rotation
 3. FPS resident if not the only senior covering inpatient services
4. Residents on outpatient rotations

The clinic manager or clinic director will make the final determination in cases that are unclear.

SUPERVISION REQUIREMENTS FOR MEDICAL CHW Graduate Medical Education Uniform Policy for California Hospitals

The requirements effective as of 2004 are more stringent than the Medicare billing requirements. We do not employ the 6-month Medicare exemption. Instead, we must have the *teaching physician present for all billable patient care services performed by unlicensed residents*. This includes all interns and all second year residents who have not received their licenses. More details about supervision guidelines are included below:

FIRST YEAR RESIDENTS

- All patients must be verbally presented in detail to the preceptor.
- *All patients seen by PGY1s must be physically seen and evaluated by the preceptor with care documented in the chart.*
- The preceptor must directly supervise all procedures.

SECOND AND THIRD YEAR RESIDENTS

- *All patients seen by unlicensed PGY2s must be physically seen and evaluated by the preceptor with care documented in the chart.*
- For licensed PGY2s and PGY3 s, all patient care must be reviewed with the preceptor during or immediately after each visit.
- E/M codes 99201, 99202, 99211 99212, 99203, and 99213 qualify for an exception and need not be seen by the preceptor unless clinically warranted.
- *The preceptor must see all patients seen by residents on visits with E/M codes 99204, 99214, 99205 and 99215.*
- *The preceptor must directly supervise all procedures*

PRECEPTOR RESPONSIBILITIES

- May supervise no more than four residents (or other students) at any given time.
- Must be on site and immediately available.
- Must assume responsibility for care given by residents.
- Must have no other responsibilities at the time of teaching (including supervision of other personnel or clinical duties). An exception will be made when there is only one resident in clinic, during which time the preceptor may see one patient per hour.
- Must review each patient's care with each resident in a timely manner and appropriately document the extent of his/her participation in the review and direction of care.
- *The preceptor must be present during all critical and key portions of all procedures.*
- Must document his/her role in supervision on the resident's chart note. If the note is dictated, he/she documents on the resident's handwritten note.
- Additional preceptor responsibilities include reviewing residents' charts for proper completion of the Medication List, Problem List, HCM, and Billing.

Approved:

Duane Bland, MD
Residency Director

_____ Date_____

Steve Namihas, MD
Associate Director

_____ Date_____